

GOLD 80 HMO 500/30 W/ CHILD DENTAL + INFERTILITY

Deductible HMO Plan

| FEATURES | MEMBER PAYS |
|---|---|
| PLAN DEDUCTIBLE Individual/Family | \$500/\$1,000 ¹ (embedded) |
| OUT-OF-POCKET MAXIMUM Individual/Family | \$6,250/\$12,500 ^{1,2} (embedded) |
| IN THE MEDICAL OFFICE Primary care visits Urgent care visits Specialty office visits Preventive exams, vaccines (immunizations) Prenatal care Postpartum care Well-child preventive care visits Allergy injections Infertility services Physical, occupational, and speech therapy Most laboratory tests Most X-rays and diagnostic testing Most MRI/CT/PET scans Outpatient surgery (per procedure) | \$30 \$30 \$30 \$0 ³ \$0 ⁴ \$0 ⁴ \$0 ⁵ \$5 50% (INF not covered) \$30 \$20 \$20 \$250 \$600 (after deductible) |
| EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance | \$250 (after deductible) \$250 (after deductible) |
| PRESCRIPTIONS Generic drugs (up to a 30-day supply) Brand-name drugs (up to a 30-day supply) Specialty drugs (up to a 30-day supply) | \$15 ⁶ \$50 ⁶ 20% per prescription up to \$250 maximum ⁶ |
| HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services Skilled nursing facility care (up to 100 days per benefit period) | \$600 per day up to 5 days per admission (after deductible) ⁷ \$250 per day up to 5 days per admission (after deductible) ⁷ |
| MENTAL HEALTH SERVICES In the medical office In the hospital | \$30 \$600 per day up to 5 days per admission (after deductible) ⁷ |
| CHEMICAL DEPENDENCY SERVICES In the medical office In the hospital (detoxification only) | \$30 \$600 per day up to 5 days per admission (after deductible) ⁷ |
| OTHER Certain durable medical equipment (DME) (supplemental and base) Certain prosthetic and orthotic devices Pediatric optical (eyewear) Pediatric vision exam Adult optical (eyewear) Adult vision exam (for eye refraction) Home health care (up to 100 visits per year) Hospice care | 20% ⁸ \$0 1 pair of eyeglasses or contact lenses per year ⁹ \$0 Not covered ¹⁰ \$0 \$0 \$0 |

¹This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual deductible, or when the family deductible is satisfied. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.

²Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.

³Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.

⁴Scheduled prenatal visits and the first postpartum visit

⁵Well-child visits through age 23 months

⁶Prescription drugs are covered in accordance with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copays; please refer to the *Evidence of Coverage* for detailed information about prescription drug copays. Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drug list, please call our Member Service Contact Center.

⁷After the 5 days, the hospital stay for the same admission is covered at no charge.

⁸Base coverage: deductible waived

Supplemental coverage: \$2,000 benefit limit per year (after deductible)

⁹Under age 19

¹⁰Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not apply to any sale, promotion, or packaged eyewear program; for any contact lens extended purchase agreement; or to low-vision aids or devices. Visit kp2020.org for Kaiser Permanente optical locations.