GOLD 80 HMO 500/35 + CHILD DENTAL ALT + INFERTILITY

Deductible HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	Individual — $500[1] Family — $1,000[1]
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $6,750[1,2] Family — $13,500[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$35
Urgent care visits	$35
Specialty office visits	$35
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5
Infertility services	50% (IVF not covered)
Physical, occupational, and speech therapy	$35
Most laboratory tests	$20
Most X-rays and diagnostic testing	$40
Most MRI/CT/PET scans	$250
Outpatient surgery (per procedure)	$600 (after deductible)
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	$250 (after deductible)
Ambulance	$250 (after deductible)
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$15[6]
Brand-name drugs (up to a 30-day supply)	$50[6]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum[6]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission (after deductible)[7]
Skilled nursing facility care (up to 100 days per benefit period)	$250 per day up to 5 days per admission (after deductible)[7]
MENTAL HEALTH SERVICES	
In the medical office	$35
In the hospital	$600 per day up to 5 days per admission (after deductible)[7]
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$35
In the hospital (detoxification only)	$600 per day up to 5 days per admission (after deductible)[7]
OTHER	
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	20%[8]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[9]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[10]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$0
Hospice care	$0

[1]This 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.

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

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

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

[6]Prescription 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.

[7]After the 5 days, additional days for the same admission are covered at no charge.

[8]Base coverage: deductible waived
Supplemental coverage: $2,000 benefit limit per year (after deductible)

[9]Under age 19

[10]Kaiser 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.

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