

**SILVER 70 HMO 2000/45 + CHILD DENTAL + INFERTILITY****Deductible HMO Plan**

<b>FEATURES</b>	<b>MEMBER PAYS</b>
<b>PLAN DEDUCTIBLE</b> Embedded	Individual — \$2,000 <sup>1</sup> Family — \$4,000 <sup>1</sup>
<b>OUT-OF-POCKET MAXIMUM</b> Embedded	Individual — \$6,800 <sup>1,2</sup> Family — \$13,600 <sup>1,2</sup>
<b>IN THE MEDICAL OFFICE</b> 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)	\$45 \$45 \$75 \$0 <sup>3</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>5</sup> \$5 50% (IVF not covered) \$45 \$40 \$70 \$300 20%
<b>EMERGENCY SERVICES</b> Emergency Department visits (waived if admitted directly to hospital) Ambulance	\$350 \$250 (after deductible)
<b>PRESCRIPTIONS</b> 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 <sup>6</sup> \$55 (after \$250 drug deductible) <sup>6</sup> 20% per prescription up to \$250 maximum (after \$250 drug deductible) <sup>6</sup>
<b>HOSPITAL CARE</b> Physicians' services, room and board, tests, medications, supplies, therapies, birth services Skilled nursing facility care (up to 30 days per benefit period)	20% (after deductible) 20% (after deductible)
<b>MENTAL HEALTH SERVICES</b> In the medical office In the hospital	\$45 20% (after deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b> In the medical office In the hospital (detoxification only)	\$45 20% (after deductible)
<b>OTHER</b> Chiropractic and acupuncture  Certain durable medical equipment (DME) (base only) 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	\$45 per visit for physician-referred acupuncture; chiropractic not covered 20% <sup>7</sup> \$0 1 pair of eyeglasses or contact lenses per year <sup>8</sup> \$0 Not covered <sup>9</sup> \$0 \$45 per day \$0

<sup>1</sup>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.

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

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

<sup>4</sup>Scheduled prenatal visits and the first postpartum visit

<sup>5</sup>Well-child visits through age 23 months

<sup>6</sup>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. For information on our formulary, including the drugs on the specialty tier, go to [kp.org/formulary](http://kp.org/formulary) or call our Member Service Contact Center.

<sup>7</sup>Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.

<sup>8</sup>Under age 19

<sup>9</sup>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](http://kp2020.org) for Kaiser Permanente optical locations.