

# GOLD 80 HMO 0/25\* + CHILD DENTAL

Copay HMO Plan

FEATURES	MEMBER PAYS
<b>PLAN DEDUCTIBLE</b> Embedded	\$0
<b>OUT-OF-POCKET MAXIMUM</b> Embedded	Individual — \$6,000 <sup>1,2</sup> Family — \$12,000 <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)	\$25 \$25 \$55 \$0 <sup>3</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>5</sup> \$5 Not covered <sup>6</sup> \$25 \$35 \$55 \$275 \$340
<b>EMERGENCY SERVICES</b> Emergency Department visits (waived if admitted directly to hospital) Ambulance	\$325 \$250
<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>7</sup> \$55 <sup>7</sup> 20% per prescription up to \$250 maximum <sup>7</sup>
<b>HOSPITAL CARE</b> 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 <sup>8</sup> \$300 per day up to 5 days per admission <sup>8</sup>
<b>MENTAL HEALTH SERVICES</b> In the medical office In the hospital	\$25 \$600 per day up to 5 days per admission <sup>8</sup>
<b>CHEMICAL DEPENDENCY SERVICES</b> In the medical office In the hospital (detoxification only)	\$25 \$600 per day up to 5 days per admission <sup>8</sup>
<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	\$25 per visit for physician-referred acupuncture; chiropractic not covered 20% <sup>9</sup> \$0 1 pair of eyeglasses or contact lenses per year <sup>10</sup> \$0 Not covered <sup>11</sup> \$0 \$30 per day \$0

<sup>1</sup>Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.

<sup>2</sup>This plan has an embedded out-of-pocket maximum. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.

<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>Infertility benefits can be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.

<sup>7</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>8</sup>After the 5 days, additional days for the same admission are covered at no charge.

<sup>9</sup>Please refer to the *Evidence of Coverage* for information on what's included in your DME benefit. Coverage is limited.

<sup>10</sup>Under age 19

<sup>11</sup>Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts can't be combined with any other Health Plan vision benefit. The discounts won't 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.