

# PLATINUM 90 HMO 0/10\* + CHILD DENTAL ALT<sup>†</sup>

## Copay HMO Plan

<sup>†</sup>The abbreviation “ALT” in the plan names designates Kaiser Permanente developed “alternate” plans that supplement those available through Covered California for Small Business. Alternate plans are available at the Platinum, Gold, and Silver levels and provide a broader range of plan benefits, including chiropractic/acupuncture, for small businesses with 1–100 employees.

FEATURES	MEMBER PAYS
<b>PLAN DEDUCTIBLE</b>	\$0
<b>OUT-OF-POCKET MAXIMUM</b> Embedded	Individual — \$3,000 <sup>1,2</sup> Family — \$6,000 <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)	\$10 \$10 \$20 \$0 <sup>3</sup> \$0 <sup>4</sup> \$0 <sup>4</sup> \$0 <sup>5</sup> \$5 Not covered <sup>6</sup> \$10 \$20 \$40 \$150 \$300
<b>EMERGENCY SERVICES</b> Emergency Department visits (waived if admitted directly to hospital) Ambulance	\$200 \$150
<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)	\$5 <sup>7</sup> \$15 <sup>7</sup> 10% 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)	\$500 per admission \$250 per admission
<b>MENTAL HEALTH SERVICES</b> In the medical office In the hospital	\$10 \$500 per admission
<b>CHEMICAL DEPENDENCY SERVICES</b> In the medical office In the hospital (detoxification only)	\$10 \$500 per admission
<b>OTHER</b> Televisits Chiropractic and acupuncture 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	\$0 \$15 per visit (20 combined visits per year) 10% <sup>8</sup> \$0 1 pair of eyeglasses or contact lenses per year <sup>9</sup> \$0 \$175 allowance <sup>10</sup> \$0 \$0 \$0

<sup>1</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>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>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>Supplemental coverage: \$2,000 benefit limit per year.

<sup>9</sup>Under age 19.

<sup>10</sup>Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months.

**This is a summary of benefits only and is subject to change.** The KFHP *Evidence of Coverage* and the KPIC *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided isn’t intended to describe all the benefits included in each plan, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.