

# BRONZE 60 HMO 6300/65\* + CHILD DENTAL

## Deductible HMO Plan

FEATURES	MEMBER PAYS
<b>PLAN DEDUCTIBLE</b> Embedded	Individual — \$6,300 <sup>1</sup> Family — \$12,600 <sup>1</sup>
<b>OUT-OF-POCKET MAXIMUM</b> Embedded	Individual — \$7,800 <sup>1,2</sup> Family — \$15,600 <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)	\$65 (after plan deductible) <sup>3</sup> \$65 (after plan deductible) <sup>3</sup> \$95 (after plan deductible) <sup>3</sup> \$0 <sup>4</sup> \$0 <sup>5</sup> \$0 <sup>5</sup> \$0 <sup>6</sup> \$5 (after plan deductible) Not covered <sup>7</sup> \$65 \$40 40% (after plan deductible) 40% (after plan deductible) 40% (after plan deductible)
<b>EMERGENCY SERVICES</b> Emergency Department visits (waived if admitted directly to hospital) Ambulance	40% (after plan deductible) 40% (after plan 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)	\$18 (after \$500 drug deductible) <sup>8</sup> 40% up to \$500 maximum (after \$500 drug deductible) <sup>8</sup> 40% up to \$500 maximum (after \$500 drug deductible) <sup>8</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)	40% (after plan deductible) 40% (after plan deductible)
<b>MENTAL HEALTH SERVICES</b> In the medical office In the hospital	\$65 (after plan deductible) <sup>3</sup> 40% (after plan deductible)
<b>CHEMICAL DEPENDENCY SERVICES</b> In the medical office In the hospital (detoxification only)	\$65 (after plan deductible) <sup>3</sup> 40% (after plan deductible)
<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 \$65 per visit (after plan deductible) <sup>3</sup> for physician-referred acupuncture; chiropractic not covered 40% (after plan deductible) <sup>9</sup> \$0 1 pair of eyeglasses or contact lenses per year <sup>10</sup> \$0 Not covered <sup>11</sup> \$0 \$40 (after plan deductible) \$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 out-of-pocket maximum (depending on the benefit), or when the family deductible or out-of-pocket maximum is satisfied. 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>Deductible is waived for first 3 visits combined for non-preventive primary care, specialty care, other practitioner care, urgent care, and mental/behavioral health and substance use disorder outpatient services.

<sup>4</sup>Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.

<sup>5</sup>Scheduled prenatal visits and the first postpartum visit.

<sup>6</sup>Well-child visits through age 23 months.

<sup>7</sup>Infertility benefits can be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.

<sup>8</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>9</sup>Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of \$2,000 per year for services. Refer to the *Evidence of Coverage* for information on what's included in your DME benefit.

<sup>10</sup>Under age 19. 1 pair of eyeglasses from a limited selection.

<sup>11</sup>Kaiser Permanente members are entitled to a 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.

**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*.