KAISER PERMANENTE®

For effective dates January 1–December 1, 2022
*Also available in Covered California and CaliforniaChoice®.

PLATINUM 90 HMO 0/10* + CHILD DENTAL ALT† + INFERTILITY

Copay HMO Plan

†The abbreviation "ALT," in certain plan names, designates Kaiser Permanente developed plans that are different from the standard plans and are available through Covered California for Small Business. This Alt plan also includes chiropractic and acupuncture benefits.

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE Embedded	$0
OUT-OF-POCKET MAXIMUM Embedded	Individual – $3,000[1,2] Family – $6,000[1,2]
IN THE MEDICAL OFFICE Primary care visits	$10
Urgent care visits	$10
Specialty office visits	$20
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5 per visit
Infertility services	50%
Physical, occupational, and speech therapy	$10
Most laboratory tests	$20
Most X-rays and diagnostic testing	$40
Most MRI/CT/PET scans	$150
Outpatient surgery (per procedure)	$300
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	$200
Ambulance	$150
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$5[6]
Brand-name drugs (up to a 30-day supply)	$15[6]
Specialty drugs (up to a 30-day supply)	10% per prescription up to $250 maximum[6]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per admission
Skilled nursing facility care (up to 100 days per benefit period)	$250 per admission
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$10
Inpatient (in the hospital)	$500 per admission
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$10
Inpatient (in the hospital) - detoxification only	$500 per admission
OTHER Televisits	$0
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	10%[7]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[8]
Pediatric vision exam	$0
Adult optical (eyewear)	$175 allowance[9]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$0
Hospice care	$0

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[1]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.

[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. For information on our formulary, including the drugs on the specialty tier, go to **kp.org/formulary** or call our Member Service Contact Center.

[7]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.

[8]Under age 19. 1 pair of eyeglasses from a limited selection.

[9]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*.