*ALSO AVAILABLE IN COVERED CALIFORNIA AND CALIFORNIA*CHOICE*

BRONZE 60 HMO 6300/75* + CHILD DENTAL

Deductible HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	Individual — $6,300[1,2] Family — $12,600[1,2]
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $7,550[1,3] Family — $15,100[1,3]
IN THE MEDICAL OFFICE	
Primary care visits	$75 (after plan deductible)[4]
Urgent care visits	$75 (after plan deductible)[4]
Specialty office visits	$105 (after plan deductible)[4]
Preventive exams, vaccines (immunizations)	$0[5]
Prenatal care	$0[6]
Postpartum care	$0[6]
Well-child preventive care visits	$0[7]
Allergy injections	$5 (after plan deductible)
Infertility services	Not covered[8]
Physical, occupational, and speech therapy	$75
Most laboratory tests	$40
Most X-rays and diagnostic testing	100% (up to out-of-pocket maximum)[2]
Most MRI/CT/PET scans	100% (up to out-of-pocket maximum)[2]
Outpatient surgery (per procedure)	100% (up to out-of-pocket maximum)[2]
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	100% (up to out-of-pocket maximum)[2]
Ambulance	100% (up to out-of-pocket maximum)[2]
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	100% per prescription up to $500 maximum (after $500 drug deductible)[9]
Brand-name drugs (up to a 30-day supply)	100% per prescription up to $500 maximum (after $500 drug deductible)[9]
Specialty drugs (up to a 30-day supply)	100% per prescription up to $500 maximum (after $500 drug deductible)[9]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	100% (up to out-of-pocket maximum)[2]
Skilled nursing facility care (up to 100 days per benefit period)	100% (up to out-of-pocket maximum)[2]
MENTAL HEALTH SERVICES	
In the medical office	$75 (after plan deductible)[4]
In the hospital	100% (up to out-of-pocket maximum)[2]
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$75 (after plan deductible)[4]
In the hospital (detoxification only)	100% (up to out-of-pocket maximum)[2]
OTHER	
Televisits	$0
Chiropractic and acupuncture	$75 per visit (after plan deductible)[4] for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	100% (up to out-of-pocket maximum)[2,10]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[11]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[12]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	100% (up to out-of-pocket maximum)[2]
Hospice care	$0

[1]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.
[2]Even when the deductible is met, member will still pay 100% coinsurance for select benefits until the out-of-pocket maximum has been met. Once the out-of-pocket maximum is met, there is no charge for covered services.
[3]Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.
[4]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.
[5]Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
[6]Scheduled prenatal visits and the first postpartum visit.
[7]Well-child visits through age 23 months.
[8]Infertility benefits can be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.
[9]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.
[10]Refer to the *Evidence of Coverage* for information on what's included in your DME benefit. Coverage is limited.
[11]Under age 19.
[12]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** 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*.

KAISER PERMANENTE®