*ALSO AVAILABLE IN COVERED CALIFORNIA AND CALIFORNIA*CHOICE*

GOLD 80 HMO 0/30* + CHILD DENTAL

Copay HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	$0
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $7,200[1,2] Family — $14,400[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$30
Urgent care visits	$30
Specialty office visits	$55
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5
Infertility services	Not covered[6]
Physical, occupational, and speech therapy	$30
Most laboratory tests	$35
Most X-rays and diagnostic testing	$55
Most MRI/CT/PET scans	$275
Outpatient surgery (per procedure)	$340
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	$325
Ambulance	$250
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$15[7]
Brand-name drugs (up to a 30-day supply)	$55[7]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission[8]
Skilled nursing facility care (up to 100 days per benefit period)	$300 per day up to 5 days per admission[8]
MENTAL HEALTH SERVICES	
In the medical office	$30
In the hospital	$600 per day up to 5 days per admission[8]
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$30
In the hospital (detoxification only)	$600 per day up to 5 days per admission[8]
OTHER	
Televisits	$0
Chiropractic and acupuncture	$30 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	20%[9]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[10]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[11]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$30 per visit
Hospice care	$0

[1]Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.

[2]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.

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

[7]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.

[8]After the 5 days, additional days for the same admission are covered at no charge.

[9]Refer to the *Evidence of Coverage* for information on what's included in your DME benefit. Coverage is limited.

[10]Under age 19.

[11]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*.

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