KAISER PERMANENTE®

For effective dates January 1–December 1, 2021
*Also available in Covered California and CaliforniaChoice®.
Covered California doesn't include child dental coverage.

GOLD 80 HMO 1000/40* + CHILD DENTAL ALT†

Deductible HMO Plan

†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
PLAN DEDUCTIBLE Embedded	Individual – $1,000[1] Family – $2,000[1]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,800[1,2] Family – $15,600[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$40
Urgent care visits	$40
Specialty office visits	$60
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	Not covered[6]
Physical, occupational, and speech therapy	$40
Most laboratory tests	$30
Most X-rays and diagnostic testing	$60
Most MRI/CT/PET scans	$350 (after plan deductible)
Outpatient surgery (per procedure)	$350
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$350
Ambulance	$350
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$20[7]
Brand-name drugs (up to a 30-day supply)	$50 (after $250 drug deductible)[7]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after $250 drug deductible)[7]
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission (after plan deductible)[8]
Skilled nursing facility care (up to 100 days per benefit period)	$300 per day up to 5 days per admission (after plan deductible)[8]
MENTAL HEALTH SERVICES In the medical office	$40
In the hospital	$600 per day up to 5 days per admission (after plan deductible)[8]
CHEMICAL DEPENDENCY SERVICES In the medical office	$40
In the hospital (detoxification only)	$600 per day up to 5 days per admission (after plan deductible)[8]
OTHER Televisits	$0
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME) (Supplemental and base)	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)	$0
Hospice care	$0

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[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]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]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]Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of $2,000 per year for services (after plan deductible). Refer to the *Evidence of Coverage* for information on what's included in your DME benefit.

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

[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*.