Bronze 60 HMO 5400/60* + Child Dental ALT[†] Copay HMO Plan

For effective dates January 1-December 1, 2024

DUTO-FOCKET MAXMUM (Embedded) NTHE MEDICAL OFFICE Primary care wishs So0 (after plan deductible) ³ Specially office wists Sol (after plan deductible) ³ Specially office wists Sol (after plan deductible) ³ Specially office wists Sol through age 23 months When the plan deductible of the plan	FEATURES	MEMBER PAYS
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Allergy injections S 5 per wist (after plan deductible) Not covered* Physical, occupational, and speech therapy S65 Most Horactory tests Most Horactory tests Most Horactory tests Most Arays and diagnostic testing Most MRI / CT / PET scans Dutpatient surgery (per procedure) Emergency department visits (waived if admitted directly to hospital) S70% (after plan deductible) Membulance Membulance Membulance FRESCRIPTIONS (up to a 30-day supply) Sement (lier 1) S70% (after plan deductible) S70% (after plan deductible) S70% (after plan deductible) S70% (after plan deductible) MOSPITAL INPATIENT CARE Physicians's services, room and board, tests, medications, supplies, behaples, birth services S70% (after plan deductible) MOSPITAL INPATIENT CARE MOSPITAL INPATIENT CARE MOSPITAL INPATIENT CARE S70% (after plan deductible) MOSPITAL INPATIENT CARE MOSPITAL INPATIENT CARE MOSPITAL INPATIENT CARE S70% (after plan deductible) MOSPITAL INPATIENT CARE MOSPITAL INPATIENT CARE S70% (after plan deductible) MOSPITAL INPATIENT CARE Dutpatient (in the medical office) S70% (after plan deductible) MOSPITAL INPATIENT CARE S70% (after plan deductible) MOSPITAL INPATIENT CARE Dutpatient (in the medical office) S70% (after plan deductible) MOSPITAL INPATIENT CARE NOSM (after plan deductible) M	and immunizations)	\$0 ^{4,5}
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### Sociation of the Company of the	SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	\$0 (after plan deductible) ³
Virtual care Chiropractic and acupuncture Cretain durable medical equipment (DME) (supplemental and base) Cretain 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) \$15 per visit (self-referral; 20 combined visits per year) \$00 1 pair of eyeglasses or contact lenses per year ¹¹ Politatric vision exam \$00 Not covered 12 Adult vision exam (for eye refraction) \$00 Home health care (up to 100 visits per year) \$00 (after plan deductible)	Inpatient (in the hospital) – detoxification only	50% (after plan deductible)
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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) \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	Chiropractic and acupuncture	\$15 per visit (self-referral; 20 combined visits per year)
Pediatric optical (eyewear) 1 pair of eyeglasses or contact lenses per year ¹¹ 90 Adult optical (eyewear) Adult vision exam (for eye refraction) Home health care (up to 100 visits per year) 1 pair of eyeglasses or contact lenses per year ¹¹ Not covered ¹² 50% (after plan deductible)	Certain durable medical equipment (DME) (supplemental and base)	50% (after plan deductible) ¹⁰
Pediatric vision exam \$0 Adult optical (eyewear) Adult vision exam (for eye refraction) Home health care (up to 100 visits per year) \$0 \$0 \$0 \$0 \$10 \$10 \$10 \$10 \$	Certain prosthetic and orthotic devices	\$0
Adult optical (eyewear) Adult vision exam (for eye refraction) Home health care (up to 100 visits per year) Not covered 12 \$0 50% (after plan deductible)	Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ¹¹
Adult vision exam (for eye refraction) \$0 Home health care (up to 100 visits per year) 50% (after plan deductible)	Pediatric vision exam	\$0
Home health care (up to 100 visits per year) 50% (after plan deductible)	Adult optical (eyewear)	Not covered 12
	Adult vision exam (for eye refraction)	\$0
Hospice care \$0	Home health care (up to 100 visits per year)	50% (after plan deductible)
	Hospice care	\$0

(continues)



For effective dates January 1-December 1, 2024

(continued)

*This plan is also offered at Covered California for Small Business and CaliforniaChoice®.

[†]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.

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. 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. 4. Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam. 5. Scheduled prenatal visits and postpartum visits. 6. Fertility benefits may be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative. 7. Laboratory and diagnostic test, X-rays and MRI/CT/PET scans related to preventive services are no charge. 8. 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. 9. Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply. 10. Both base and supplemental DME are covered (after plan deductible). 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. 11. Under age 19. One pair of eyeglasses from a limited selection. 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 <u>Evidence of Coverage</u> and the KPIC <u>Certificate of Insurance</u> 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 <u>Evidence of Coverage</u> or <u>Certificate of Insurance</u>.