

# Platinum 90 HMO 0/10\* + Child Dental ALT<sup>†</sup>

## Copay HMO Plan

For effective dates January 1-December 1, 2024

FEATURES	MEMBER PAYS
<b>PLAN DEDUCTIBLE</b> (Embedded)	\$0
<b>OUT-OF-POCKET MAXIMUM</b> (Embedded)	Individual \$3,000 <sup>1,2</sup> / Family \$6,000 <sup>1,2</sup>
<b>IN THE MEDICAL OFFICE</b>	
Primary care visits	\$10
Urgent care visits	\$10
Specialty office visits	\$20
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	\$0 <sup>3,4</sup>
Well-child preventive care visits	\$0 through age 23 months
Allergy injections	\$5 per visit
Fertility services	Not covered <sup>5</sup>
Physical, occupational, and speech therapy	\$10
Most laboratory tests	\$20 <sup>6</sup>
Most X-rays and diagnostic testing	\$40 <sup>6</sup>
Most MRI / CT / PET scans	\$150 <sup>6</sup>
Outpatient surgery (per procedure)	\$300
<b>EMERGENCY SERVICES</b>	
Emergency department visits (waived if admitted directly to hospital)	\$200
Ambulance	\$150
<b>PRESCRIPTIONS (up to a 30-day supply)</b>	
Generic (Tier 1)	\$5 <sup>7,8</sup>
Brand-name (Tier 2)	\$15 <sup>7,8</sup>
Specialty drugs (Tier 4)	10% per prescription up to \$250 maximum <sup>7,8</sup>
<b>HOSPITAL INPATIENT CARE</b>	
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
<b>MENTAL HEALTH SERVICES</b>	
Outpatient (in the medical office)	\$10
Inpatient (in the hospital)	\$500 per admission
<b>SUBSTANCE USE DISORDER SERVICES</b>	
Outpatient (in the medical office)	\$10
Inpatient (in the hospital) – detoxification only	\$500 per admission
<b>OTHER</b>	
Virtual care	\$0
Chiropractic and acupuncture	\$15 per visit (self-referral; 20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	10% <sup>9</sup>
Certain prosthetic and orthotic devices	\$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year <sup>10</sup>
Pediatric vision exam	\$0
Adult optical (eyewear)	\$175 allowance <sup>11</sup>
Adult vision exam (for eye refraction)	\$0
Home health care (up to 100 visits per year)	\$0
Hospice care	\$0

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## 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 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 postpartum visits. **5.** Fertility benefits may be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative. **6.** Laboratory and diagnostic test, X-rays and MRI/CT/PET scans related to preventive services are no charge. **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](http://kp.org/formulary) or call our Member Service Contact Center. **8.** Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply. **9.** 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. **10.** Under age 19. One pair of eyeglasses from a limited selection. **11.** 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*.