Gold 80 HDHP HMO 1750/15%* + Child Dental ALT†

Copay HMO Plan

For effective dates January 1–December 1, 2024

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE (Embedded)	Self-only $1,750[1,2] / Individual $3,200[1,2] / Family $3,500[1,2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual $3,700[1,3] / Family $7,400[1,3]
IN THE MEDICAL OFFICE Primary care visits	15% (after plan deductible)
Urgent care visits	15% (after plan deductible)
Specialty office visits	15% (after plan deductible)
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0[4,5]
Well-child preventive care visits	$0 through age 23 months
Allergy injections	15% per visit (after plan deductible)
Fertility services	Not covered[6]
Physical, occupational, and speech therapy	15% (after plan deductible)
Most laboratory tests	15% (after plan deductible)[7]
Most X-rays and diagnostic testing	15% (after plan deductible)[7]
Most MRI / CT / PET scans	15% (after plan deductible)[7]
Outpatient surgery (per procedure)	15% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	15% (after plan deductible)
Ambulance	15% (after plan deductible)
PRESCRIPTIONS (up to a 30-day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	 $15 (after plan deductible)[8,9] $45 (after plan deductible)[8,9] 15% up to $250 maximum (after plan deductible)[8,9]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	15% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	15% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	15% (after plan deductible)
Inpatient (in the hospital)	15% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	15% (after plan deductible)
Inpatient (in the hospital) – detoxification only	15% (after plan deductible)
OTHER Virtual care	$0 (after plan deductible)[10]
Chiropractic and acupuncture	15% per visit after deductible for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	15%[11]
Certain prosthetic and orthotic devices	$0 (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[12]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[13]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	15% (after plan deductible)
Hospice care	0% (after plan deductible)

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For effective dates January 1–December 1, 2024

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*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.** Self-only: a family of 1 member. Individual: each member in a family of 2 or more members. Family: entire family of 2 or more members. **3.** Out-of-pocket maximum is the maximum amount an individual or family will pay for all covered services in a year. **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.** For HSA-qualified HDHP HMO members, all scheduled, non-preventive telehealth visits (phone and video). **12.** Under age 19. One pair of eyeglasses from a limited selection. **13.** 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*.