$30/$3,400 GRANDFATHERED (NONMETAL)

HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	Individual – $3,400[1] Family – $6,000[1]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $5,950[1,2] Family – $11,900[1,2]
IN THE MEDICAL OFFICE Primary care visits	$30 (after plan deductible)
Urgent care visits	$30 (after plan deductible)
Specialty office visits	$30 (after plan deductible)
Preventive exams, vaccines (immunizations)	$0
Prenatal care	$0[3]
Postpartum care	$0[3]
Well-child preventive care visits	$0[4]
Allergy injections	$5 per visit (after plan deductible)
Fertility services	Not covered[5]
Physical, occupational, and speech therapy	$30 (after plan deductible)
Most laboratory tests	$10 (after plan deductible)
Most X-rays and diagnostic testing	$10 (after plan deductible)
Most MRI/CT/PET scans	30% (after plan deductible)[6]
Outpatient surgery (per procedure)	30% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	30% (after plan deductible)
Ambulance	$100 (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$10 (after plan deductible)[7]
Brand-name drugs (up to a 30-day supply)	$30 (after plan deductible)[7]
Specialty drugs (up to a 30-day supply)	$30 (after plan deductible)[7]
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	30% (after plan deductible)
MENTAL HEALTH SERVICES In the medical office	$30 (after plan deductible) individual $15 (after plan deductible) group
In the hospital	30% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$30 (after plan deductible) individual $5 (after plan deductible) group
In the hospital (detoxification only)	30% (after plan deductible)
OTHER Televisits	$0 (after plan deductible)
Acupuncture	$30 per visit for physician-referred acupuncture
Certain durable medical equipment (DME) (base only)	20% (after plan deductible)[8]
Certain prosthetic and orthotic devices	$0 (after plan deductible)
Pediatric optical (eyewear)	Not covered[9]
Pediatric vision exam	$30 (after plan deductible)
Adult optical (eyewear)	Not covered[9]
Adult vision exam (for eye refraction)	$30 (after plan deductible)
Home health care (up to 100 visits per year)	$0 (after plan deductible)
Hospice care	$0 (after plan deductible)

(continues)

(continued)

Kaiser Permanente plans don't include a pre-existing condition clause.
Preventive services on this plan are available at no cost share. For a complete list of preventive services, please refer to the *Evidence of Coverage* or **business.kp.org**.

[1]This is an embedded plan. For a family of 2 or more, an individual deductible is part of the family deductible. Each family member becomes eligible for copayments or coinsurance either after meeting his or her individual deductible or after the family collectively meets the family deductible. The same methodology applies to the out-of-pocket maximum.
[2]Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a calendar year.
[3]Scheduled prenatal visits and postpartum visits.
[4]Well-child visits through age 23 months
[5]Enhanced fertility coverage is available at additional cost, please contact your your broker or Kaiser Permanente Representative for details.
[6]Up to a maximum of $50 per procedure.
[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 copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.
[8]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.
[9]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*.