

BRONZE 60 HSA HMO 4500/40%* W/ CHILD DENTAL

HSA-Qualified Deductible HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	\$4,500/\$9,000 ¹ (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	\$6,500/\$13,000 ^{1,2} (embedded)
IN THE MEDICAL OFFICE Primary care visits Urgent care visits Specialty office visits Preventive exams, vaccines (immunizations) Prenatal care Postpartum care Well-child preventive care visits Allergy injections Infertility services Physical, occupational, and speech therapy Most laboratory tests Most X-rays and diagnostic testing Most MRI/CT/PET scans Outpatient surgery (per procedure)	40% (after deductible) 40% (after deductible) 40% (after deductible) \$0 ³ \$0 ⁴ \$0 (after deductible) ⁵ \$0 ⁶ 40% (after deductible) Not covered ⁷ 40% (after deductible) 40% (after deductible) 40% (after deductible) 40% (after deductible) 40% (after deductible)
EMERGENCY SERVICES Emergency Department visits Ambulance	40% (after deductible) 40% (after deductible)
PRESCRIPTIONS Generic drugs (up to a 100-day supply) Brand-name drugs (up to a 100-day supply) Specialty drugs (up to a 30-day supply)	40% (after plan deductible) ⁸ 40% (after plan deductible) ⁸ 40% (after plan deductible) ⁸
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services Skilled nursing facility care (up to 100 days per benefit period)	40% (after deductible) 40% (after deductible)
MENTAL HEALTH SERVICES In the medical office In the hospital	40% (after deductible) 40% (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office In the hospital (detoxification only)	40% (after deductible) 40% (after deductible)
OTHER Certain durable medical equipment (DME) (base only) 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) Hospice care	40% (after deductible) ⁹ \$0 (after deductible) 1 pair of eyeglasses or contact lenses per year ¹⁰ \$0 Not covered ¹¹ \$0 \$0 (after deductible) \$0 (after deductible)

¹This 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 are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.

²Out-of-pocket maximum is the maximum amount an individual or family will pay for all covered services in a year.

³Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.

⁴Scheduled prenatal visits

⁵First postpartum visit only covered at no charge

⁶Well-child visits through age 23 months

⁷Infertility benefits can be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.

⁸Prescription 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.

⁹Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.

¹⁰Under age 19

¹¹Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.