PLATINUM 90 HMO 0/15* W/ CHILD DENTAL

Copay HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Individual/Family	$0
OUT-OF-POCKET MAXIMUM	
Individual/Family	$2,500/$5,000[1,2] (embedded)
IN THE MEDICAL OFFICE	
Primary care visits	$15
Urgent care visits	$15
Specialty office visits	$15
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5
Infertility services	Not covered[6]
Physical, occupational, and speech therapy	$15
Most laboratory tests	$20
Most X-rays and diagnostic testing	$40
Most MRI/CT/PET scans	$100
Outpatient surgery (per procedure)	$250
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	$150
Ambulance	$150
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$5[7]
Brand-name drugs (up to a 30-day supply)	$15[7]
Specialty drugs (up to a 30-day supply)	10% per prescription up to $250 maximum[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$250 per admission
Skilled nursing facility care (up to 100 days per benefit period)	$250 per admission
MENTAL HEALTH SERVICES	
In the medical office	$15
In the hospital	$250 per admission
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$15
In the hospital (detoxification only)	$250 per admission
OTHER	
Certain durable medical equipment (DME) (supplemental and base)	10%[8]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[9]
Pediatric vision exam	$0
Adult optical (eyewear)	$175 allowance[10]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$0
Hospice care	$0

[1]This plan has an embedded out-of-pocket maximum. 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.

[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 the first postpartum visit

[5]Well-child visits through age 23 months

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

[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; please refer to the *Evidence of Coverage* for detailed information about prescription drug copays. Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drug list, please call our Member Service Contact Center.

[8]Supplemental coverage: $2,000 benefit limit per year

[9]Under age 19

[10]Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months

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