

GOLD 80 HRA HMO 2250/35 + CHILD DENTALDeductible HMO with HRA Plan¹

(HRA can be administered through Kaiser Permanente)

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE Embedded	Individual — \$2,250 ² Family — \$4,500 ²
OUT-OF-POCKET MAXIMUM Embedded	Individual — \$7,000 ^{2,3} Family — \$14,000 ^{2,3}
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)	\$35 \$35 \$35 \$0 ⁴ \$0 ⁵ \$0 ⁵ \$0 ⁶ \$5 (after plan deductible) Not covered ⁷ \$35 (after plan deductible) 25% (after plan deductible) 25% (after plan deductible) 25% (after plan deductible) 25% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital) Ambulance	25% (after plan deductible) 25% (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply) Brand-name drugs (up to a 30-day supply) Specialty drugs (up to a 30-day supply)	\$15 ⁸ \$30 ⁸ 20% per prescription up to \$250 maximum 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)	25% (after plan deductible) 25% (after plan deductible)
MENTAL HEALTH SERVICES In the medical office In the hospital	\$35 25% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office In the hospital (detoxification only)	\$35 25% (after plan deductible)
OTHER Chiropractic and acupuncture 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	\$35 per visit for physician-referred acupuncture; chiropractic not covered 50% ⁹ \$0 1 pair of eyeglasses or contact lenses per year ¹⁰ \$0 Not covered ¹¹ \$0 \$0 \$0

¹Groups selecting the Gold HRA 2250/35 Deductible HMO with HRA plan must establish and fund an HRA for each enrolled employee. The allowable funding range is \$200 to \$500 per employee. If the group covers dependents, the allowable funding range per family is \$400 to \$1,000.

²This 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.

³Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.

⁴Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.

⁵Scheduled prenatal visits and the first postpartum visit

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's 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 won'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*.