



Plan Highlights

Metal Plans

For effective dates January 1 to December 1, 2020

Notes for all plans

- All plans have an unlimited lifetime maximum benefit while insured.
- Kaiser Permanente plans don't include a pre-existing condition clause.
- The copay HMO plans, HSA-qualified high deductible health plans, deductible HMO plans, and the deductible HMO plans with HRA are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the Preferred Provider Organization (PPO) plans. The chiropractic/acupuncture benefit is administered by American Specialty Health Plans of California, Inc.
- All plans cover the essential health benefits, as defined by Affordable Care Act (ACA) regulations, which include child dental services. When employees and dependents enroll in the medical plan(s) you've chosen, we'll also enroll them in a separate child dental plan underwritten by Delta Dental of California. PPO medical plan members receive child dental benefits as part of their medical coverage and not as a separate plan.
- This booklet is a summary only. The KFHP *Evidence of Coverage* and the KPIC *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided in this brochure isn't intended to describe all of the benefits included in each plan, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.
- Summary of Benefits and Coverage (SBC) documents for all of our plans are available at kp.org/smallbusiness-sbc/ca. These documents summarize important information about your health coverage options, so you can easily compare Kaiser Permanente benefits and coverage with those of other carriers and make an informed choice.

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Your medical plan options

When it comes to health care, you expect plans that are simple and easy to use – not just for you, but for your employees. You need options that give you flexibility and control over your health care dollars. And you want it all from a trusted partner who can guide you every step of the way. That’s the solution you get with Kaiser Permanente.

Our plans give your employees what they need to be healthier and more productive every day – top doctors, a focus on prevention, innovative health promotion tools, and high-quality, personalized care.

Copay HMO plans – A copay is the fixed dollar amount you pay for certain covered services or prescriptions. Copay plans feature mostly set fees and no deductible, so you know in advance how much you’ll pay for services like doctor’s office visits and prescriptions.

- Platinum 90 HMO 0/10 + Child Dental Alt¹
- Platinum 90 HMO 0/15 + Child Dental

Deductible HMO plans – A deductible is the set amount you must pay for most covered services within a plan year before your health plan begins to pay. After you reach your deductible, you’ll start paying a copay or coinsurance (a percentage of the full charges) for most covered services for the rest of the plan year until you reach your out-of-pocket maximum. Depending on your plan, you may pay copays or coinsurance for some services without having to reach your deductible.

- Gold 80 HMO 250/25 + Child Dental
- Gold 80 HMO 500/30 + Child Dental Alt¹
- Silver 70 HMO 1650/55 + Child Dental Alt¹
- Silver 70 HMO 1800/55 + Child Dental Alt¹
- Silver 70 HMO 2250/50 + Child Dental
- Bronze 60 HMO 6300/65 + Child Dental

HSA-qualified High Deductible Health Plans (HDHP) – These deductible HMO plans can be paired with a health savings account (HSA) administered through Kaiser Permanente, giving your employees the option to open an HSA. They can contribute pretax or tax-deductible dollars² to the HSA and use that money to pay for qualified medical expenses. For a complete list of qualified medical expenses, see IRS Publication 502, *Medical and Dental Expenses*, at [irs.gov/publications](https://www.irs.gov/publications). (Refer to page 4 for more details.)

- Silver 70 HDHP HMO 2500/20% + Child Dental
- Bronze 60 HDHP HMO 6900/0 + Child Dental

Deductible HMO with HRA plan – This deductible plan is paired with a health reimbursement arrangement (HRA), which you’ll set up for your employees. You contribute money into your employees’ HRAs, which they can use to pay for the health care services they receive. Because this money isn’t considered part of their wages, they won’t pay federal income taxes on it.² (Refer to page 4 for more details.)

- Gold 80 HRA HMO 2250/35 + Child Dental

PPO insurance plans – These plans give you referral-free access to contracted PHCS physicians or any other licensed provider of choice. An online directory of participating providers can be found by visiting multiplan.com/kaiser.

- Platinum 90 PPO 0/15 + Child Dental
- Gold 80 PPO 250/25 + Child Dental
- Silver 70 PPO 2250/50 + Child Dental
- Bronze 60 PPO 6300/65 + Child Dental

¹The abbreviation “ALT” in the plan names designates Kaiser Permanente developed “alternate” plans that supplement those available through Covered California for Small Business and CaliforniaChoice®.

²Tax references relate to federal income tax only. Consult with your financial or tax adviser for information about state income tax laws. Federal and state tax laws and regulations are subject to change.



Health Payment Accounts

HSA/HRA administration through Kaiser Permanente

Pair a health savings account (HSA) or a health reimbursement arrangement (HRA) administered through Kaiser Permanente with your health plan, to get an integrated solution that lets you spend less time managing your employees' health care and more time focusing on your business.

HSA^s

- An HSA is an employee-owned account that can be used to pay qualified medical expenses.
- Your employees get triple tax savings with pre-tax contributions through payroll, tax-free interest earnings, and tax-free withdrawals to pay for qualified expenses.¹
- A monthly administrative fee of \$3.25, per employee account, can be paid by you or your employees.
- Available to eligible employees enrolled in the Silver 70 HDHP HMO 2500/20% + Child Dental or the Bronze 60 HDHP HMO 6900/0 + Child Dental benefit plans.²

HRA^s³

- An HRA lets you contribute money for your employees to use to pay qualified medical expenses on a tax-free basis.¹
- There are multiple HRA types available ranging from limited to more comprehensive coverage.
- A monthly administrative fee of \$3.75, per employee account, is paid by you, the employer.
- Available to employees enrolled in the Gold 80 HRA HMO 2250/35 + Child Dental benefit plan.

- **Easy online access** – Your employees can take advantage of 24-hour access to their health plan and Health Payment Account through kp.org and through Kaiser Permanente's Balance Tracker app for smartphones and mobile devices.
- **A variety of payment options** – No matter which account type you choose to offer, your employees will get convenient payment options that make access to their Health Payment Account funds simple while reducing paperwork.
 - Our HSA and certain HRA types come with our health payment card, which works just like a debit card. This means employees don't have to submit claims or file for reimbursement when paying qualified medical expenses using their card.
 - Other HRA types offer employees the convenience of automatic reimbursement for eligible medical services received and paid for at Kaiser Permanente facilities.

To learn more about your account options, contact your Kaiser Permanente representative.

¹Tax references relate to federal income tax only. Consult with your financial or tax adviser for information about state income tax laws. Federal and state tax laws and regulations are subject to change.

²Refer to IRS Publication 502 for a list of qualified medical and dental expenses.

³Groups selecting the Gold HRA HMO 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.



Understanding health plans

In the following “Plan highlights” section, you’ll get an overview of what your employees can expect to pay for certain services with our plans. There are 4 main categories of coverage, known as “metal plans” – Platinum, Gold, Silver and Bronze. These 4 categories offer different levels of copays, coinsurance, and deductibles for essential health benefits.

Here’s a quick look at how to use the chart.

	Bronze 60 ^① HMO 6300/65* + Child Dental
FEATURES	Deductible HMO Plan
② PLAN DEDUCTIBLE Embedded	Individual – \$6,300 ¹⁰ ③ Family – \$12,600 ¹⁰
④ OUT-OF-POCKET MAXIMUM Embedded	Individual – \$7,800 ^{1,10} ③ Family – \$15,600 ^{1,10}
IN THE MEDICAL OFFICE	
Primary care visits	\$65 (after plan deductible) ²
Urgent care visits	\$65 (after plan deductible) ²
Specialty office visits	\$95 (after plan deductible) ²
Preventive exams, vaccines (immunizations)	\$0 ¹² ⑤
Prenatal care	\$0 ³
Postpartum care	\$0 ³
Well-child preventive care visits	\$0 ²³
Allergy injections	\$5 (after plan deductible)
Infertility services	Not covered ¹⁷
Physical, occupational, and speech therapy	\$65 ⑥
Most laboratory tests	\$40
Most X-rays and diagnostic testing	40% (after plan deductible)
Most MRI/CT/PET scans	40% (after plan deductible)
Outpatient surgery (per procedure)	40% (after plan deductible)
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	40% (after plan deductible)
Ambulance	40% (after plan deductible)
PRESCRIPTIONS	
Generic drugs	\$18 (after \$500 drug deductible) (up to a 30-day supply) ²⁴
Brand-name drugs	40% up to \$500 maximum (after \$500 drug deductible) (up to a 30-day supply) ²⁴
Specialty drugs	40% up to \$500 maximum (after \$500 drug deductible) (up to a 30-day supply) ²⁴
HOSPITAL CARE	
Physicians’ services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible) ⑦
Skilled nursing facility care (up to 100 days per benefit period)	40% (after plan deductible)
MENTAL HEALTH SERVICES	
In the medical office	\$65 (after plan deductible) ²
In the hospital	40% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES	
In the medical office	\$65 (after plan deductible) ²
In the hospital (detoxification only)	40% (after plan deductible)
OTHER	
Televisits	\$0
Chiropractic and acupuncture	\$65 per visit (after plan deductible) ² for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (Supplemental and base)	40% (after plan deductible) ^{5,6}
Certain prosthetic and orthotic devices	\$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷
Pediatric vision exam	\$0
Adult optical (eyewear)	Not covered ⁸
Adult vision exam (for eye refraction)	\$0
Home health care (up to 100 visits per year)	40% (after plan deductible)
Hospice care	\$0

Refer to page 15 for the medical plan footnotes.
Refer to page 16 for the child dental benefits.

1. Actuarial value

The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, members would be responsible for 30% of the costs of all covered benefits. However, members could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on their actual health care needs and the terms of their policy.

2. Plan deductible

The set amount employees pay for most covered services within a plan year before the health plan begins paying. This is included in the out-of-pocket maximum.

3. Embedded accumulation

Each individual family member will begin paying copays or coinsurance after meeting his or her individual deductible, or when the family deductible is satisfied, whichever comes first. Also, 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, whichever comes first. Not all services are subject to the deductible and/or out-of-pocket maximum.

4. Out-of-pocket maximum

The maximum amount an individual or family will pay for all covered services in a year before the plan starts paying 100% for most or all covered services.

5. Preventive care at no charge

Most preventive services are covered at no charge and aren’t subject to the deductible.

6. Copay

The set amount employees will pay for certain services.

7. Coinsurance

The percentage of the total cost for certain services that an employee will pay after meeting the deductible up to the out-of-pocket maximum.

Kaiser Permanente Platinum HMO plans

Plan Highlights

For effective dates 1/1/20-12/1/20

*Also available in Covered California and CaliforniaChoice.
Covered California doesn't include child dental coverage.

	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/15* + Child Dental
FEATURES	Copay HMO Plan	Copay HMO Plan
PLAN DEDUCTIBLE	\$0	\$0
OUT-OF-POCKET MAXIMUM Embedded	Individual – \$3,000 ^{1,28} Family – \$6,000 ^{1,28}	Individual – \$4,500 ^{1,28} Family – \$9,000 ^{1,28}
IN THE MEDICAL OFFICE		
Primary care visits	\$10	\$15
Urgent care visits	\$10	\$15
Specialty office visits	\$20	\$30
Preventive exams, vaccines (immunizations)	\$0 ¹²	\$0 ¹²
Prenatal care	\$0 ³	\$0 ³
Postpartum care	\$0 ³	\$0 ³
Well-child preventive care visits	\$0 ²³	\$0 ²³
Allergy injections	\$5	\$5
Infertility services	Not covered ¹⁷	Not covered ¹⁷
Physical, occupational, and speech therapy	\$10	\$15
Most laboratory tests	\$20	\$15
Most X-rays and diagnostic testing	\$40	\$30
Most MRI/CT/PET scans	\$150	\$75
Outpatient surgery (per procedure)	\$300	\$125
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	\$200	\$150
Ambulance	\$150	\$150
PRESCRIPTIONS		
Generic drugs	\$5 ²⁴ (up to a 30-day supply)	\$5 ²⁴ (up to a 30-day supply)
Brand-name drugs	\$15 ²⁴ (up to a 30-day supply)	\$15 ²⁴ (up to a 30-day supply)
Specialty drugs	10% per prescription up to \$250 maximum ²⁴ (up to a 30-day supply)	10% per prescription up to \$250 maximum ²⁴ (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	\$500 per admission	\$250 per day up to 5 days per admission ²⁶
Skilled nursing facility care (up to 100 days per benefit period)	\$250 per admission	\$150 per day up to 5 days per admission ²⁶
MENTAL HEALTH SERVICES		
In the medical office	\$10	\$15
In the hospital	\$500 per admission	\$250 per day up to 5 days per admission ²⁶
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$10	\$15
In the hospital (detoxification only)	\$500 per admission	\$250 per day up to 5 days per admission ²⁶
OTHER		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$15 per visit (20 combined visits per year)	\$15 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (Supplemental and base)	10% ^{5,6}	10% ^{5,6}
Certain prosthetic and orthotic devices	\$0	\$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷	1 pair of eyeglasses or contact lenses per year ⁷
Pediatric vision exam	\$0	\$0
Adult optical (eyewear)	\$175 allowance ³¹	Not covered ⁸
Adult vision exam (for eye refraction)	\$0	\$0
Home health care (up to 100 visits per year)	\$0	\$20 per visit
Hospice care	\$0	\$0

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Gold HMO plans

Plan Highlights

For effective dates 1/1/20-12/1/20

*Also available in Covered California and CaliforniaChoice.
Covered California doesn't include child dental coverage.

	Gold 80 HMO 250/25* + Child Dental	Gold 80 HMO 500/30* + Child Dental Alt	Gold 80 HRA HMO 2250/35 + Child Dental
FEATURES	Deductible HMO Plan	Deductible HMO Plan	Deductible HMO with HRA Plan ³⁰ (HRA can be administered through Kaiser Permanente)
PLAN DEDUCTIBLE Embedded	Individual – \$250 ¹⁰ Family – \$500 ¹⁰	Individual – \$500 ¹⁰ Family – \$1,000 ¹⁰	Individual – \$2,250 ¹⁰ Family – \$4,500 ¹⁰
OUT-OF-POCKET MAXIMUM Embedded	Individual – \$7,800 ^{1,28} Family – \$15,600 ^{1,28}	Individual – \$7,000 ^{1,10} Family – \$14,000 ^{1,10}	Individual – \$7,800 ^{1,10} Family – \$15,600 ^{1,10}
IN THE MEDICAL OFFICE			
Primary care visits	\$25	\$30	\$35
Urgent care visits	\$25	\$30	\$35
Specialty office visits	\$50	\$35	\$50
Preventive exams, vaccines (immunizations)	\$0 ¹²	\$0 ¹²	\$0 ¹²
Prenatal care	\$0 ³	\$0 ³	\$0 ³
Postpartum care	\$0 ³	\$0 ³	\$0 ³
Well-child preventive care visits	\$0 ²³	\$0 ²³	\$0 ²³
Allergy injections	\$5	\$5	\$5 (after plan deductible)
Infertility services	Not covered ¹⁷	Not covered ¹⁷	Not covered ¹⁷
Physical, occupational, and speech therapy	\$25	\$30	\$35 (after plan deductible)
Most laboratory tests	\$25	\$20	25% (after plan deductible)
Most X-rays and diagnostic testing	\$65	\$40	25% (after plan deductible)
Most MRI/CT/PET scans	\$275	\$300 (after plan deductible)	25% (after plan deductible)
Outpatient surgery (per procedure)	\$340	\$600 (after plan deductible)	25% (after plan deductible)
EMERGENCY SERVICES			
Emergency Department visits (waived if admitted directly to hospital)	\$250 (after plan deductible)	\$250 (after plan deductible)	25% (after plan deductible)
Ambulance	\$250 (after plan deductible)	\$250 (after plan deductible)	25% (after plan deductible)
PRESCRIPTIONS			
Generic drugs	\$15 ²⁴ (up to a 30-day supply)	\$15 ²⁴ (up to a 30-day supply)	\$15 ²⁴ (up to a 30-day supply)
Brand-name drugs	\$50 ²⁴ (up to a 30-day supply)	\$50 ²⁴ (up to a 30-day supply)	\$30 (after \$100 drug deductible) ²⁴ (up to a 30-day supply)
Specialty drugs	20% per prescription up to \$250 maximum ²⁴ (up to a 30-day supply)	20% per prescription up to \$250 maximum ²⁴ (up to a 30-day supply)	20% per prescription up to \$250 maximum (after \$100 drug deductible) ²⁴ (up to a 30-day supply)
HOSPITAL CARE			
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	\$600 per day up to 5 days per admission (after plan deductible) ²⁶	\$600 per day up to 5 days per admission (after plan deductible) ²⁶	25% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	\$300 per day up to 5 days per admission (after plan deductible) ²⁶	\$300 per day up to 5 days per admission (after plan deductible) ²⁶	25% (after plan deductible)
MENTAL HEALTH SERVICES			
In the medical office	\$25	\$30	\$35
In the hospital	\$600 per day up to 5 days per admission (after plan deductible) ²⁶	\$600 per day up to 5 days per admission (after plan deductible) ²⁶	25% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES			
In the medical office	\$25	\$30	\$35
In the hospital (detoxification only)	\$600 per day up to 5 days per admission (after plan deductible) ²⁶	\$600 per day up to 5 days per admission (after plan deductible) ²⁶	25% (after plan deductible)
OTHER			
Televisits	\$0	\$0	\$0
Chiropractic and acupuncture	\$25 per visit for physician-referred acupuncture; chiropractic not covered	\$15 per visit (20 combined visits per year)	\$35 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (Supplemental and base)	20% ^{5,6,27}	20% ^{5,6,27}	50% ^{5,6,27}
Certain prosthetic and orthotic devices	\$0	\$0	\$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷	1 pair of eyeglasses or contact lenses per year ⁷	1 pair of eyeglasses or contact lenses per year ⁷
Pediatric vision exam	\$0	\$0	\$0
Adult optical (eyewear)	Not covered ⁸	Not covered ⁸	Not covered ⁸
Adult vision exam (for eye refraction)	\$0	\$0	\$0
Home health care (up to 100 visits per year)	\$30 per visit	\$0	\$0
Hospice care	\$0	\$0	\$0

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Refer to page 4 for HRA details.

Kaiser Permanente Silver HMO plans

Plan Highlights

For effective dates 1/1/20-12/1/20

*Also available in Covered California and CaliforniaChoice.
Covered California doesn't include child dental coverage.

	Silver 70 HMO 1650/55* + Child Dental Alt	Silver 70 HMO 1800/55* + Child Dental Alt
FEATURES	Deductible HMO Plan	Deductible HMO Plan
PLAN DEDUCTIBLE Embedded	Individual – \$1,650 ¹⁰ Family – \$3,300 ¹⁰	Individual – \$1,800 ¹⁰ Family – \$3,600 ¹⁰
OUT-OF-POCKET MAXIMUM Embedded	Individual – \$7,800 ^{1,10} Family – \$15,600 ^{1,10}	Individual – \$7,800 ^{1,10} Family – \$15,600 ^{1,10}
IN THE MEDICAL OFFICE		
Primary care visits	\$55	\$55
Urgent care visits	\$55	\$55
Specialty office visits	\$80	\$75
Preventive exams, vaccines (immunizations)	\$0 ¹²	\$0 ¹²
Prenatal care	\$0 ³	\$0 ³
Postpartum care	\$0 ³	\$0 ³
Well-child preventive care visits	\$0 ²³	\$0 ²³
Allergy injections	\$5	\$5
Infertility services	Not covered ¹⁷	Not covered ¹⁷
Physical, occupational, and speech therapy	\$65	\$65
Most laboratory tests	\$25	\$25 (after plan deductible)
Most X-rays and diagnostic testing	\$75 (after plan deductible)	\$55 (after plan deductible)
Most MRI/CT/PET scans	\$350 (after plan deductible)	\$350 (after plan deductible)
Outpatient surgery (per procedure)	40% (after plan deductible)	45% (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	40% (after plan deductible)	45% (after plan deductible)
Ambulance	40% (after plan deductible)	45% (after plan deductible)
PRESCRIPTIONS		
Generic drugs	\$20 ²⁴ (up to a 30-day supply)	\$20 ²⁴ (up to a 30-day supply)
Brand-name drugs	\$75 (after \$350 drug deductible) ²⁴ (up to a 30-day supply)	\$75 (after \$350 drug deductible) ²⁴ (up to a 30-day supply)
Specialty drugs	20% per prescription up to \$250 maximum (after \$350 drug deductible) ²⁴ (up to a 30-day supply)	20% per prescription up to \$250 maximum (after \$350 drug deductible) ²⁴ (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	45% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	40% (after plan deductible)	45% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	\$55	\$55
In the hospital	40% (after plan deductible)	45% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$55	\$55
In the hospital (detoxification only)	40% (after plan deductible)	45% (after plan deductible)
OTHER		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$15 per visit (20 combined visits per year)	\$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME) (Supplemental and base)	40% ^{5,6,27}	45% ^{5,6,27}
Certain prosthetic and orthotic devices	\$0	\$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷	1 pair of eyeglasses or contact lenses per year ⁷
Pediatric vision exam	\$0	\$0
Adult optical (eyewear)	Not covered ⁸	Not covered ⁸
Adult vision exam (for eye refraction)	\$0	\$0
Home health care (up to 100 visits per year)	\$0	\$0
Hospice care	\$0	\$0

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Silver HMO plans

Plan Highlights

For effective dates 1/1/20-12/1/20

*Also available in Covered California and CaliforniaChoice.
Covered California doesn't include child dental coverage.

	Silver 70 HMO 2250/50* + Child Dental	Silver 70 HDHP HMO 2500/20%* + Child Dental
FEATURES	Deductible HMO Plan	HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)
PLAN DEDUCTIBLE Embedded	Individual – \$2,250 ¹⁰ Family – \$4,500 ¹⁰	Self-only – \$2,500 ^{10,32} Individual – \$2,800 ^{10,32} Family – \$5,000 ^{10,32}
OUT-OF-POCKET MAXIMUM Embedded	Individual – \$7,800 ^{1,10} Family – \$15,600 ^{1,10}	Individual – \$6,850 ^{10,29} Family – \$13,700 ^{10,29}
IN THE MEDICAL OFFICE		
Primary care visits	\$50	20% (after plan deductible)
Urgent care visits	\$50	20% (after plan deductible)
Specialty office visits	\$85	20% (after plan deductible)
Preventive exams, vaccines (immunizations)	\$0 ¹²	\$0 ¹²
Prenatal care	\$0 ³	\$0 ⁴
Postpartum care	\$0 ³	\$0 (after plan deductible) ¹⁶
Well-child preventive care visits	\$0 ²³	\$0 ²³
Allergy injections	\$5	20% (after plan deductible)
Infertility services	Not covered ¹⁷	Not covered ¹⁷
Physical, occupational, and speech therapy	\$50	20% (after plan deductible)
Most laboratory tests	\$40	20% (after plan deductible)
Most X-rays and diagnostic testing	\$85	20% (after plan deductible)
Most MRI/CT/PET scans	\$300	20% (after plan deductible)
Outpatient surgery (per procedure)	20%	20% (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	\$400 (after plan deductible)	20% (after plan deductible)
Ambulance	\$250 (after plan deductible)	20% (after plan deductible)
PRESCRIPTIONS		
Generic drugs	\$17 (after \$300 drug deductible) ²⁴ (up to a 30-day supply)	20% per prescription up to \$250 maximum (after plan deductible) ²⁴ (up to a 30-day supply)
Brand-name drugs	\$65 (after \$300 drug deductible) ²⁴ (up to a 30-day supply)	20% per prescription up to \$250 maximum (after plan deductible) ²⁴ (up to a 30-day supply)
Specialty drugs	20% per prescription up to \$250 maximum (after \$300 drug deductible) ²⁴ (up to a 30-day supply)	20% per prescription up to \$250 maximum (after plan deductible) ²⁴ (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	20% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	20% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	\$50	20% (after plan deductible)
In the hospital	20% (after plan deductible)	20% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$50	20% (after plan deductible)
In the hospital (detoxification only)	20% (after plan deductible)	20% (after plan deductible)
OTHER		
Televisits	\$0	\$0 (after plan deductible) ³³
Chiropractic and acupuncture	\$50 per visit for physician-referred acupuncture; chiropractic not covered	20% per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (Supplemental and base)	20% ^{5,6,27}	20% (after plan deductible) ^{5,6}
Certain prosthetic and orthotic devices	\$0	\$0 (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷	1 pair of eyeglasses or contact lenses per year ⁷
Pediatric vision exam	\$0	\$0
Adult optical (eyewear)	Not covered ⁸	Not covered ⁸
Adult vision exam (for eye refraction)	\$0	\$0
Home health care (up to 100 visits per year)	\$45 per visit	20% (after plan deductible)
Hospice care	\$0	\$0 (after plan deductible)

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Refer to page 4 for HSA details.

Kaiser Permanente Bronze HMO plans

Plan Highlights

For effective dates 1/1/20-12/1/20

*Also available in Covered California and CaliforniaChoice.
Covered California doesn't include child dental coverage.

	Bronze 60 HMO 6300/65* + Child Dental	Bronze 60 HDHP HMO 6900/0* + Child Dental
FEATURES	Deductible HMO Plan	HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)
PLAN DEDUCTIBLE Embedded	Individual – \$6,300 ¹⁰ Family – \$12,600 ¹⁰	Individual – \$6,900 ¹⁰ Family – \$13,800 ¹⁰
OUT-OF-POCKET MAXIMUM Embedded	Individual – \$7,800 ^{1,10} Family – \$15,600 ^{1,10}	Individual – \$6,900 ^{10,29} Family – \$13,800 ^{10,29}
IN THE MEDICAL OFFICE		
Primary care visits	\$65 (after plan deductible) ²	\$0 (after plan deductible)
Urgent care visits	\$65 (after plan deductible) ²	\$0 (after plan deductible)
Specialty office visits	\$95 (after plan deductible) ²	\$0 (after plan deductible)
Preventive exams, vaccines (immunizations)	\$0 ¹²	\$0 ¹²
Prenatal care	\$0 ³	\$0 ⁴
Postpartum care	\$0 ³	\$0 (after plan deductible) ¹⁶
Well-child preventive care visits	\$0 ²³	\$0 ²³
Allergy injections	\$5 (after plan deductible)	\$0 (after plan deductible)
Infertility services	Not covered ¹⁷	Not covered ¹⁷
Physical, occupational, and speech therapy	\$65	\$0 (after plan deductible)
Most laboratory tests	\$40	\$0 (after plan deductible)
Most X-rays and diagnostic testing	40% (after plan deductible)	\$0 (after plan deductible)
Most MRI/CT/PET scans	40% (after plan deductible)	\$0 (after plan deductible)
Outpatient surgery (per procedure)	40% (after plan deductible)	\$0 (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	40% (after plan deductible)	\$0 (after plan deductible)
Ambulance	40% (after plan deductible)	\$0 (after plan deductible)
PRESCRIPTIONS		
Generic drugs	\$18 (after \$500 drug deductible) ²⁴ (up to a 30-day supply)	\$0 (after plan deductible) ²⁴ (up to a 30-day supply)
Brand-name drugs	40% up to \$500 maximum (after \$500 drug deductible) ²⁴ (up to a 30-day supply)	\$0 (after plan deductible) ²⁴ (up to a 30-day supply)
Specialty drugs	40% up to \$500 maximum (after \$500 drug deductible) ²⁴ (up to a 30-day supply)	\$0 (after plan deductible) ²⁴ (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	\$0 (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	40% (after plan deductible)	\$0 (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	\$65 (after plan deductible) ²	\$0 (after plan deductible)
In the hospital	40% (after plan deductible)	\$0 (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$65 (after plan deductible) ²	\$0 (after plan deductible)
In the hospital (detoxification only)	40% (after plan deductible)	\$0 (after plan deductible)
OTHER		
Televisits	\$0	\$0 (after plan deductible) ³³
Chiropractic and acupuncture	\$65 per visit (after plan deductible) ² for physician-referred acupuncture; chiropractic not covered	\$0 per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (Supplemental and base)	40% (after plan deductible) ^{5,6}	\$0 (after plan deductible) ^{5,6}
Certain prosthetic and orthotic devices	\$0	\$0 (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷	1 pair of eyeglasses or contact lenses per year ⁷
Pediatric vision exam	\$0	\$0
Adult optical (eyewear)	Not covered ⁸	Not covered ⁸
Adult vision exam (for eye refraction)	\$0	\$0
Home health care (up to 100 visits per year)	40% (after plan deductible)	\$0 (after plan deductible)
Hospice care	\$0	\$0 (after plan deductible)

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Refer to page 4 for HSA details.

Kaiser Permanente Platinum PPO insurance plans

For effective dates 1/1/20–12/1/20

Plan Highlights

	Platinum 90 PPO 0/15 + Child Dental	
FEATURES	Participating Provider Tier (in-network)⁹	Non-Participating Provider Tier (out-of-network)⁹
PLAN DEDUCTIBLE Embedded	\$0	Individual – \$500 ¹⁰ Family – \$1,000 ¹⁰
OUT-OF-POCKET MAXIMUM Embedded	Individual – \$4,500 ¹¹ Family – \$9,000 ¹¹	Individual – \$9,000 ^{10,11} Family – \$18,000 ^{10,11}
IN THE MEDICAL OFFICE		
Primary care visits	\$15	30% (after plan deductible)
Urgent care visits	\$15	30% (after plan deductible)
Specialty office visits	\$30	30% (after plan deductible)
Preventive exams, vaccines (immunizations)	\$0 ¹²	30% ¹²
Prenatal care	\$0 ^{3,13,14}	30% ^{3,13,14}
Postpartum care	\$0 ³	30% ³
Well-child preventive care visits	\$0	30%
Allergy injections	10%	30% (after plan deductible)
Infertility services	50% ¹⁵	Not covered
Physical, occupational, and speech therapy	\$15	30% (after plan deductible)
Most laboratory tests	\$15	30% (after plan deductible)
Most X-rays and diagnostic testing	\$30	30% (after plan deductible)
Most MRI/CT/PET scans	10%	30% (after plan deductible)
Outpatient surgery (per procedure)	10%	30% (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	\$150	\$150
Ambulance	\$150	\$150
PRESCRIPTIONS		
Generic drugs		\$5 ^{18,19} (up to a 30-day supply)
Brand-name drugs		\$15 ^{18,19} (up to a 30-day supply)
Specialty drugs		10% per prescription up to \$250 maximum ¹⁹ (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	10%	30% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	10%	30% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	\$15	30% (after plan deductible)
In the hospital	10%	30% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$15	30% (after plan deductible)
In the hospital (detoxification only)	10%	30% (after plan deductible)
OTHER		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$15 per visit (acupuncture services only)	30% per visit (after plan deductible) (acupuncture services only)
Certain durable medical equipment (DME) (Supplemental and base)	10% ^{21,22}	30% (after plan deductible) ^{21,22}
Certain prosthetic and orthotic devices	10%	30% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷	10% (after plan deductible) ⁷
Pediatric vision exam	\$0	\$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	\$0	Not covered
Home health care (up to 100 visits per year)	10% ²⁵	30% (after plan deductible) ²⁵
Hospice care	\$0	30% (after plan deductible)

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Gold PPO insurance plans

For effective dates 1/1/20-12/1/20

Plan Highlights

	Gold 80 PPO 250/25 + Child Dental	
FEATURES	Participating Provider Tier (in-network)⁹	Non-Participating Provider Tier (out-of-network)⁹
PLAN DEDUCTIBLE Embedded	Individual – \$250 ¹⁰ Family – \$500 ¹⁰	Individual – \$1,000 ¹⁰ Family – \$2,000 ¹⁰
OUT-OF-POCKET MAXIMUM Embedded	Individual – \$7,800 ¹¹ Family – \$15,600 ¹¹	Individual – \$15,600 ^{10,11} Family – \$31,200 ^{10,11}
IN THE MEDICAL OFFICE		
Primary care visits	\$25	40% (after plan deductible)
Urgent care visits	\$25	40% (after plan deductible)
Specialty office visits	\$50	40% (after plan deductible)
Preventive exams, vaccines (immunizations)	\$0 ¹²	40% ¹²
Prenatal care	\$0 ^{3,13,14}	40% ^{3,13,14}
Postpartum care	\$0 ³	40% ³
Well-child preventive care visits	\$0	40%
Allergy injections	20%	40% (after plan deductible)
Infertility services	50% ¹⁵	Not covered
Physical, occupational, and speech therapy	\$25	40% (after plan deductible)
Most laboratory tests	\$25	40% (after plan deductible)
Most X-rays and diagnostic testing	\$65	40% (after plan deductible)
Most MRI/CT/PET scans	20%	40% (after plan deductible)
Outpatient surgery (per procedure)	20%	40% (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	\$250 (after plan deductible)	\$250 (after plan deductible)
Ambulance	\$250 (after plan deductible)	\$250 (after plan deductible)
PRESCRIPTIONS		
Generic drugs		\$15 ^{18,19} (up to a 30-day supply)
Brand-name drugs		\$50 ^{18,19} (up to a 30-day supply)
Specialty drugs		20% per prescription up to \$250 maximum ¹⁹ (up to a 30-day supply)
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	40% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	\$25	40% (after plan deductible)
In the hospital	20% (after plan deductible)	40% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$25	40% (after plan deductible)
In the hospital (detoxification only)	20% (after plan deductible)	40% (after plan deductible)
OTHER		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$25 per visit (acupuncture services only)	40% per visit (after plan deductible) (acupuncture services only)
Certain durable medical equipment (DME) (Supplemental and base)	20% ^{21,22}	40% (after plan deductible) ^{21,22}
Certain prosthetic and orthotic devices	20%	40% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷	20% (after plan deductible) ⁷
Pediatric vision exam	\$0	\$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	\$0	Not covered
Home health care (up to 100 visits per year)	20% ²⁵	40% (after plan deductible) ²⁵
Hospice care	\$0	40% (after plan deductible)

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Silver PPO insurance plans

For effective dates 1/1/20-12/1/20

Plan Highlights

FEATURES	Silver 70 PPO 2250/50 + Child Dental	
	Participating Provider Tier (in-network) ⁹	Non-Participating Provider Tier (out-of-network) ⁹
PLAN DEDUCTIBLE Embedded	Individual – \$2,250 ¹⁰ Family – \$4,500 ¹⁰	Individual – \$4,500 ¹⁰ Family – \$9,000 ¹⁰
OUT-OF-POCKET MAXIMUM Embedded	Individual – \$7,800 ^{10,11} Family – \$15,600 ^{10,11}	Individual – \$15,600 ^{10,11} Family – \$31,200 ^{10,11}
IN THE MEDICAL OFFICE		
Primary care visits	\$50	40% (after plan deductible)
Urgent care visits	\$50	40% (after plan deductible)
Specialty office visits	\$85	40% (after plan deductible)
Preventive exams, vaccines (immunizations)	\$0 ¹²	40% ¹²
Prenatal care	\$0 ^{3,13,14}	40% ^{3,13,14}
Postpartum care	\$0 ³	40% ³
Well-child preventive care visits	\$0	40%
Allergy injections	20%	40% (after plan deductible)
Infertility services	50% (after plan deductible) ¹⁵	Not covered
Physical, occupational, and speech therapy	\$50	40% (after plan deductible)
Most laboratory tests	\$40	40% (after plan deductible)
Most X-rays and diagnostic testing	\$85	40% (after plan deductible)
Most MRI/CT/PET scans	\$300	40% (after plan deductible)
Outpatient surgery (per procedure)	20%	40% (after plan deductible)
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	\$400 (after plan deductible)	\$400 (after plan deductible)
Ambulance	\$250 (after plan deductible)	\$250 (after plan deductible)
PRESCRIPTIONS		
Generic drugs	\$17 (after \$300 drug deductible) ^{18,19} (up to a 30-day supply)	
Brand-name drugs	\$65 (after \$300 drug deductible) ^{18,19} (up to a 30-day supply)	
Specialty drugs	20% per prescription up to \$250 maximum (after \$300 drug deductible) ¹⁹ (up to a 30-day supply)	
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	40% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	\$50	40% (after plan deductible)
In the hospital	20% (after plan deductible)	40% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$50	40% (after plan deductible)
In the hospital (detoxification only)	20% (after plan deductible)	40% (after plan deductible)
OTHER		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$50 per visit (acupuncture services only)	40% per visit (after plan deductible) (acupuncture services only)
Certain durable medical equipment (DME) (Supplemental and base)	20% ^{21,22}	40% (after plan deductible) ^{21,22}
Certain prosthetic and orthotic devices	20%	40% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷	20% (after plan deductible) ⁷
Pediatric vision exam	\$0	\$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	\$0	Not covered
Home health care (up to 100 visits per year)	\$45 ²⁵	40% (after plan deductible) ²⁵
Hospice care	\$0	40% (after plan deductible)

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Bronze PPO insurance plans

For effective dates 1/1/20-12/1/20

Plan Highlights

	Bronze 60 PPO 6300/65 + Child Dental	
FEATURES	Participating Provider Tier (in-network) ⁹	Non-Participating Provider Tier (out-of-network) ⁹
PLAN DEDUCTIBLE Embedded	Individual – \$6,300 ¹⁰ Family – \$12,600 ¹⁰	Individual – \$12,600 ¹⁰ Family – \$25,200 ¹⁰
OUT-OF-POCKET MAXIMUM Embedded	Individual – \$7,800 ^{10,11} Family – \$15,600 ^{10,11}	Individual – \$15,600 ^{10,11} Family – \$31,200 ^{10,11}
IN THE MEDICAL OFFICE		
Primary care visits	\$65 (after plan deductible) ²	100% (up to out-of-pocket maximum) ²⁰
Urgent care visits	\$65 (after plan deductible) ²	100% (up to out-of-pocket maximum) ²⁰
Specialty office visits	\$95 (after plan deductible) ²	100% (up to out-of-pocket maximum) ²⁰
Preventive exams, vaccines (immunizations)	\$0 ¹²	40% ¹²
Prenatal care	\$0 ^{3,13,14}	40% ^{3,13,14}
Postpartum care	\$0 ³	40% ³
Well-child preventive care visits	\$0	40%
Allergy injections	\$65	100% (up to out-of-pocket maximum) ²⁰
Infertility services	40% (after plan deductible) ¹⁵	Not covered
Physical, occupational, and speech therapy	\$65	100% (up to out-of-pocket maximum) ²⁰
Most laboratory tests	\$40	100% (up to out-of-pocket maximum) ²⁰
Most X-rays and diagnostic testing	40% (after plan deductible)	100% (up to out-of-pocket maximum) ²⁰
Most MRI/CT/PET scans	40% (after plan deductible)	100% (up to out-of-pocket maximum) ²⁰
Outpatient surgery (per procedure)	40% (after plan deductible)	100% (up to out-of-pocket maximum) ²⁰
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	40% (after plan deductible)	40% (up to out-of-pocket maximum) ²⁰
Ambulance	40% (after plan deductible)	40% (up to out-of-pocket maximum) ²⁰
PRESCRIPTIONS		
Generic drugs	\$18 (after \$500 drug deductible) ^{18,19} (up to a 30-day supply)	
Brand-name drugs	40% per prescription up to \$500 maximum (after \$500 drug deductible) ^{18,19} (up to a 30-day supply)	
Specialty drugs	40% per prescription up to \$500 maximum (after \$500 drug deductible) ¹⁹ (up to a 30-day supply)	
HOSPITAL CARE		
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	100% (up to out-of-pocket maximum) ²⁰
Skilled nursing facility care (up to 100 days per benefit period)	40% (after plan deductible)	100% (up to out-of-pocket maximum) ²⁰
MENTAL HEALTH SERVICES		
In the medical office	\$65 (after plan deductible) ²	100% (up to out-of-pocket maximum) ²⁰
In the hospital	40% (after plan deductible)	100% (up to out-of-pocket maximum) ²⁰
CHEMICAL DEPENDENCY SERVICES		
In the medical office	\$65 (after plan deductible) ²	100% (up to out-of-pocket maximum) ²⁰
In the hospital (detoxification only)	40% (after plan deductible)	100% (up to out-of-pocket maximum) ²⁰
OTHER		
Televisits	\$0	\$0
Chiropractic and acupuncture	\$65 per visit (after plan deductible) ² (acupuncture services only)	100% per visit (up to out-of-pocket maximum) ²⁰ (acupuncture services only)
Certain durable medical equipment (DME) (Supplemental and base)	40% (after plan deductible) ^{21,22}	100% (up to out-of-pocket maximum) ^{20,21,22}
Certain prosthetic and orthotic devices	40% (after plan deductible)	100% (up to out-of-pocket maximum) ²⁰
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year ⁷	100% (up to out-of-pocket maximum) ^{7,20}
Pediatric vision exam	\$0	\$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	\$0	Not covered
Home health care (up to 100 visits per year)	40% (after plan deductible)	100% (up to out-of-pocket maximum) ^{20,25}
Hospice care	\$0	100% (up to out-of-pocket maximum) ²⁰

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Footnotes for medical plans

Cost-share amounts for all in-network services accumulate toward the out-of-pocket maximum.

Preventive services are available at no cost share except for services from the non-participating providers. For a complete list of preventive services, please refer to the *Evidence of Coverage, Certificate of Insurance, or account.kp.org*.

Kaiser Permanente plans don't include a pre-existing condition clause.

¹Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.

²Deductible is waived for first 3 visits combined for non-preventive primary care, specialty care, other practitioner care, urgent care, and mental/behavioral health and substance use disorder outpatient services.

³Scheduled prenatal visits and the first postpartum visit.

⁴Scheduled prenatal visits.

⁵Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of \$2,000 per year for services.

⁶Refer to the *Evidence of Coverage* for information on what's included in your DME benefit.

⁷Under age 19.

1 pair of eyeglasses from a limited selection.

⁸Kaiser 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.

⁹Payments are based upon the maximum allowable charge for covered services. Maximum allowable charge means the lesser of: the usual, customary, and reasonable charges; the negotiated rate; or the actual billed charges. The maximum allowable charge may be less than the amount actually billed by the provider. Covered persons may be responsible for payment of any amounts in excess of the maximum allowable charge for a covered service.

¹⁰This 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.

¹¹Covered charges incurred toward satisfaction of the out-of-pocket maximum at the non-participating provider tier won't accumulate toward satisfaction of the out-of-pocket maximum on the participating provider tier. Likewise, covered charges incurred toward satisfaction of the out-of-pocket maximum on the participating provider tier won't accumulate toward satisfaction of the out-of-pocket maximum on the non-participating provider tier. For a complete understanding of the out-of-pocket maximum, please refer to your *Certificate of Insurance*.

¹²Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.

¹³Routine prenatal care office visits are covered as required under the Affordable Care Act (ACA). This includes the initial and subsequent histories, physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis.

¹⁴Delivery and inpatient care for mother and baby are covered under your inpatient services benefit. For a complete understanding of birth services, please see your *KPIC Certificate of Insurance*.

¹⁵Benefits payable for treatment of infertility are limited to \$1,000 per year for services provided by participating providers. Infertility includes GIFT. In vitro fertilization isn't covered. Benefits payable for diagnosis of infertility will be covered on the same basis as any other illness.

¹⁶First postpartum visit only, covered at no charge.

¹⁷Infertility benefits can be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.

¹⁸Insured is responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug when the insured requests a brand-name drug and a generic version is available.

¹⁹Your plan has an open drug formulary; however, select prescription drugs may be excluded from coverage. Please refer to your *KPIC Certificate of Insurance* for a complete list of limitations and exclusions. Regardless of your provider, prescriptions must be filled at a MedImpact pharmacy. Please call MedImpact at **800-788-2949** for a participating pharmacy.

²⁰Even when the deductible is met, member will still pay 100% coinsurance for select benefits until the out-of-pocket maximum has been met. Once the out-of-pocket maximum is met, there is no charge for covered services.

²¹Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of \$2,000 per year for services from the participating providers and non-participating providers, excluding diabetic-testing supplies and equipment.

²²Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and aren't subject to the DME maximum limit of \$2,000 per year.

²³Well-child visits through age 23 months.

²⁴Prescription 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.

²⁵Limit doesn't apply to physical, occupational, and speech therapist visits in the home.

²⁶After the 5 days, additional days for the same admission are covered at no charge.

²⁷Supplemental coverage: \$2,000 benefit limit per year (after plan deductible).

²⁸This plan has an embedded out-of-pocket maximum. 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.

²⁹Out-of-pocket maximum is the maximum amount an individual or family will pay for all covered services in a year.

³⁰Groups selecting the Gold HRA HMO 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.

³¹Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months.

³²Self-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.

³³For HSA-qualified HDHP HMO members, all scheduled, non-preventive telehealth visits (phone and video).



Child dental benefits

Child dental services is one of the essential health benefits required to be provided in conjunction with your ACA metal medical plan(s). When employees and their dependents enroll in the HMO medical plan(s) you've chosen, we'll also enroll them in a separate child dental benefit underwritten by Delta Dental of California. Child dental benefits for HMO members are provided through the DeltaCare USA network. Child dental benefits for PPO members are provided through the Delta Dental PPO network.

	Child dental benefits for HMO plans	Child dental benefits for PPO insurance plans ¹
SERVICES	Member pays	Member pays
DEDUCTIBLE	\$0	\$0
OUT-OF-POCKET (OOP) MAXIMUM	\$350/child \$700/multichild	\$0 ²
WAITING PERIOD	None	None
OFFICE VISIT	\$0	\$0
DIAGNOSTIC AND PREVENTIVE		
Periodic and comprehensive – oral evaluation	\$0	\$0
Bitewing X-rays	\$0	\$0
Prophylaxis cleaning	\$0	\$0
Fluoride treatments	\$0	\$0
Space maintainers	\$0	\$0
Sealant repair	\$0	\$0
PERIODONTICS		
Maintenance	\$30	50%
Scaling and root planing	\$30	50%
Surgery – osseous (includes flap entry and closure)	\$265	50%
RESTORATIVE		
Fillings – primary or permanent amalgam	\$25	20%
Composite crowns – resin-based one surface anterior	\$30	20%
Crown – porcelain	\$300	20%
ENDODONTICS		
Therapeutic pulpotomy	\$40	50%
Root canal – anterior	\$195	50%
Root canal – molar	\$300	50%
PROSTHODONTICS		
Complete denture	\$300	50%
Reline maxillary denture – chairside and limitations is “Partial”	\$60	50%
Reline maxillary denture – laboratory and limitations is “Partial”	\$90	50%
ORAL AND MAXILLOFACIAL SURGERY		
Extraction – erupted tooth or exposed root	\$65	50%
Surgical removal of erupted tooth	\$120	50%
ORTHODONTICS (MEDICALLY NECESSARY)	\$350 ³	50%

¹The child dental benefits are embedded into all metal PPO medical plans.

²No separate child dental OOP Maximum – applied to medical OOP Maximum

³Orthodontics includes medically necessary orthodontia only.



A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION



Kaiser Permanente Insurance Company



Chiropractic and acupuncture

Combined coverage for chiropractic and acupuncture care is included with the following plans:

- Platinum 90 HMO 0/10 + Child Dental Alt
- Gold 80 HMO 500/30 + Child Dental Alt
- Silver 70 HMO 1650/55 + Child Dental Alt
- Silver 70 HMO 1800/55 + Child Dental Alt

Services are administered by American Specialty Health Plans of California, Inc®. (ASH Plans).

FEATURES	
Office visit copay	\$15 per visit
Office visit limit	20 combined visits per year
Chiropractic appliance benefit	Chiropractic appliances are provided up to a maximum of \$50 per year when prescribed and provided by an ASH Plans participating chiropractor as part of your chiropractic care.
X-rays and laboratory tests	\$0

Services

Chiropractic services are covered when a participating chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders. Acupuncture services are covered when a participating acupuncturist finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders, nausea, or pain. You can obtain services from any ASH Plans participating chiropractors and acupuncturists without a referral from a Kaiser Permanente Plan physician.

Office visits: Covered services are limited to medically necessary chiropractic and acupuncture services authorized and provided by ASH Plans participating chiropractors and acupuncturists.

X-rays and laboratory tests: Medically necessary X-rays and laboratory tests are covered when prescribed as part of your chiropractic care by a participating chiropractor and provided by an appropriately licensed participating provider that has contracted with ASH Plans to provide those services.

Emergency services: Covered chiropractic services are those emergency services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system. Covered acupuncture services are those emergency services provided for the sudden and unexpected treatment of a neuromusculoskeletal disorder, nausea, or pain. These conditions and injuries must manifest themselves by acute symptoms of sufficient severity, including severe pain, such that a reasonable layperson with no special knowledge of health, medicine, chiropractic care, or acupuncture could reasonably expect that a delay of immediate chiropractic care or acupuncture could result in (1) placing your health in serious jeopardy, (2) serious impairment to your bodily functions, or (3) serious dysfunction of any bodily organ or part.

Participating chiropractors and acupuncturists

ASH Plans contracts with participating chiropractors and other participating providers to provide covered chiropractic services, including laboratory tests, X-rays, and chiropractic appliances. ASH Plans

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contracts with participating acupuncturists to provide acupuncture care (including adjunctive therapies, such as acupressure, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture). You must receive covered services from an ASH Plans participating provider, except for emergency chiropractic and acupuncture services and services that aren't available from participating providers that are previously authorized by ASH Plans. The list of participating chiropractors and acupuncturists is available on the ASH Plans website at ashlink.com/ash/kp or from the ASH Plans Member Services Department at **800-678-9133**. The list of participating chiropractors and acupuncturists is subject to change at any time without notice.

How to obtain covered services

To obtain covered services, schedule an initial examination with an ASH Plans participating provider. If additional services are required, your participating chiropractor or acupuncturist will prepare a treatment plan. The ASH Plans Clinical Services Manager will authorize the treatment plan if the services are medically necessary. ASH Plans will disclose to you, upon request, the process that it uses to authorize a treatment plan. If you have questions or concerns, please contact the ASH Plans Member Services Department.

This is a summary and is intended to highlight only the most frequently asked questions about the chiropractic and acupuncture benefit, including copays. Please refer to the *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for a detailed description of the chiropractic and acupuncture benefits, including exclusions and limitations, emergency chiropractic services, and emergency acupuncture services.

Kaiser Foundation Health Plan, Inc. (Health Plan), contracts with American Specialty Health Plans of California, Inc. (ASH Plans), to make the ASH Plans network of participating chiropractors and participating acupuncturists available to you. You can obtain covered services from any participating chiropractor or participating acupuncturist without a referral from a Plan physician. Cost sharing is due when you receive covered services. Please see the definitions section of your *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for terms you should know.

Getting assistance

If you have a question or concern regarding the services you received from a participating provider, you may call ASH Plans Member Services at **800-678-9133** (TTY users, call **711**), weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

ASH Plans Member Services
P.O. Box 509002
San Diego, CA 92150-9002

Dispute resolution

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as why you believe a decision was in error or why you're dissatisfied with services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *Evidence of Coverage*.

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