KAISER PERMANENTE®

Small Business
CALIFORNIA

Plan comparison guide

Kaiser Permanente for small businesses ■ For effective dates January 1-December 1, 2022

Use this guide to compare your current grandfathered (nonmetal) plan with a metal plan.

In this guide, you can see how certain benefits and cost sharing have changed from a grandfathered (nonmetal) plan to a metal plan.

Although there are different benefits, out-of-pocket expenses, and premiums with the grandfathered (nonmetal) plans, the metal plans offer a number of robust features to help your employees get richer benefits, such as coverage for preventive care visits, essential health benefits, and more.

If you have any questions, please call **800-790-4661, option 3,** to speak with our Small Business Services, Customer Service Account Management Team.

This is a comparison 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*.

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$5 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$5 Copayment HMO	Platinum 90 HMO 0/10* + Child Dental Alt
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$1,500/$3,000	$3,000/$6,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$5	$10
Specialty office visits	$5	$20
Urgent care visits	$5	$10
Most laboratory tests	$10	$20
Most X-rays and diagnostic testing	$10	$40
Outpatient surgery per procedure	$5	$300
PRESCRIPTIONS Generic drugs	$5 (up to a 100-day supply; does not apply to out-of-pocket maximum)	$5 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$15 (up to a 100-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	10% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$0	$500 per admission
OTHER Certain durable medical equipment (DME)	20% (base coverage, plus supplemental coverage up to $2,000 per year)	10% (base coverage, plus supplemental coverage up to $2,000 per year combined)[1]
Certain prosthetic and orthotic devices	$0	$0
Infertility	50% (IVF not covered)	Not covered
Adult optical (eyewear)	$150 allowance (every 24 months)	$175 allowance
Pediatric optical (eyewear)	$150 allowance (every 24 months)	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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$15 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$15 Copayment HMO	Platinum 90 HMO 0/20* + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$2,500/$5,000	$4,500/$9,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$15	$20
Specialty office visits	$15	$30
Urgent care visits	$15	$20
Most laboratory tests	$10	$20
Most X-rays and diagnostic testing	$10	$30
Outpatient surgery per procedure	$100	$125
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$5 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$25 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$20 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	10% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$200 per day (up to overall out-of-pocket maximum)	$250 per day up to 5 days per admission, then no charge
OTHER Certain durable medical equipment (DME)	20% (base coverage, plus supplemental coverage up to $2,000 per year)	10% (base coverage, plus supplemental coverage up to $2,000 per year combined)[1]
Certain prosthetic and orthotic devices	$0	$0
Infertility	50% (IVF not covered)	Not covered
Adult optical (eyewear)	$150 allowance (every 24 months)	Not covered
Pediatric optical (eyewear)	$150 allowance (every 24 months)	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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$20 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$20 Copayment HMO	Platinum 90 HMO 0/20* + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$2,500/$5,000	$4,500/$9,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$20	$20
Specialty office visits	$20	$30
Urgent care visits	$20	$20
Most laboratory tests	$10	$20
Most X-rays and diagnostic testing	$10	$30
Outpatient surgery per procedure	$150	$125
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$5 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$20 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	10% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$300 per day (up to overall out-of-pocket maximum)	$250 per day (up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	20% (base coverage, plus supplemental coverage up to $2,000 per year)	10% (base coverage, plus supplemental coverage up to $2,000 per year combined)[1]
Certain prosthetic and orthotic devices	$0	$0
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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$30 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$30 Copayment HMO	Gold 80 HMO 0/30* + Child Dental Alt
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$3,000/$6,000	$7,000/$14,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30	$30
Specialty office visits	$30	$35
Urgent care visits	$30	$30
Most laboratory tests	$10	$30
Most X-rays and diagnostic testing	$10	$40
Outpatient surgery per procedure	$200	$320
PRESCRIPTIONS Generic drugs	$10 (up to a 100-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$35 (after pharmacy deductible; up to a 100-day supply; does not apply to out-of-pocket maximum)	$40 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$400 per day (up to overall out-of-pocket maximum)	$600 per day (up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	50% (base coverage only)[1]	20% (base coverage, plus supplemental coverage up to $2,000 per year combined)[1]
Certain prosthetic and orthotic devices	$0	$0
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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$50 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$50 Copayment HMO	Gold 80 HMO 0/30* + Child Dental Alt
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000	$7,000/$14,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$50	$30
Specialty office visits	$50	$35
Urgent care visits	$50	$30
Most laboratory tests	$10	$30
Most X-rays and diagnostic testing	$10	$40
Outpatient surgery per procedure	$250	$320
PRESCRIPTIONS Generic drugs	$10 (up to a 100-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$35 (after pharmacy deductible; up to a 100-day supply; does not apply to out-of-pocket maximum)	$40 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per day (up to overall out-of-pocket maximum)	$600 per day (up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	50% (base coverage only)[1]	20% (base coverage, plus supplemental coverage up to $2,000 per year combined)[1]
Certain prosthetic and orthotic devices	$0	$0
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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$30/$1,000 DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$1,000 Deductible HMO	Gold 80 HMO 1000/40* + Child Dental Alt
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$1,000/$2,000 (embedded)	$1,000/$2,000 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000 (embedded)	$7,800/$15,600 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30	$40
Specialty office visits	$30	$60
Urgent care visits	$50	$40
Most laboratory tests	$10 (after deductible)	$30
Most X-rays and diagnostic testing	$10 (after deductible)	$60
Outpatient surgery per procedure	$250 (after deductible)	$350
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$20 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$50 after $250 drug deductible (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per day (after deductible; up to overall out-of-pocket maximum)	$600 per day (after plan deductible; up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)[1]	20% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)[1]
Certain prosthetic and orthotic devices	$0	$0
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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$30/$1,500 DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$1,500 Deductible HMO	Silver 70 HMO 1650/55* + Child Dental Alt
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$1,500/$3,000 (embedded)	$1,650/$3,300 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000 (embedded)	$8,200/$16,400 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30	$55
Specialty office visits	$30	$80
Urgent care visits	$30	$55
Most laboratory tests	$10 (after deductible)	$30
Most X-rays and diagnostic testing	$10 (after deductible)	$75
Outpatient surgery per procedure	$250 (after deductible)	40% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$20 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$75 after $350 drug deductible (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after $350 drug deductible) (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per day (after deductible; up to overall out-of-pocket maximum)	40% (after plan deductible; up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)[1]	40% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)[1]
Certain prosthetic and orthotic devices	$0	$0
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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$40/$2,000 DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$40/$2,000 Deductible HMO	Silver 70 HMO 2100/55* + Child Dental Alt
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$2,000/$4,000 (embedded)	$2,100/$4,200 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$4,500/$9,000 (embedded)	$8,200/$16,400 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$40	$55
Specialty office visits	$40	$80
Urgent care visits	$40	$55
Most laboratory tests	$10 (after deductible)	$30
Most X-rays and diagnostic testing	$10 (after deductible)	$75
Outpatient surgery per procedure	30% (after deductible)	45% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$20 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$35 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$75 (after $500 drug deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after $500 drug deductible; up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% per admission (after deductible; up to overall out-of-pocket maximum)	45% per admission (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)[1]	45% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)[1]
Certain prosthetic and orthotic devices	$0	$0
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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$0/$2,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$0/$2,000 HSA-Qualified Deductible HMO	Silver 70 HDHP HMO 2500/20%* + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$2,000/$4,000 (aggregate)	Self-only – $2,500 Individual – $2,800 Family – $5,000 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000 (aggregate)	Individual – $6,850 Family – $13,700 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$0 (after deductible)	20% (after plan deductible)
Specialty office visits	$0 (after deductible)	20% (after plan deductible)
Urgent care visits	$0 (after deductible)	20% (after plan deductible)
Most laboratory tests	$0 (after deductible)	20% (after plan deductible)
Most X-rays and diagnostic testing	$0 (after deductible)	20% (after plan deductible)
Outpatient surgery per procedure	$150 (after deductible)	20% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	20% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	20% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$300 per day (after deductible; up to overall out-of-pocket maximum)	20% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	$0 (after deductible; base coverage only)[1]	20% (after plan deductible; base coverage, plus supplemental coverage up to $2,000 per year combined)[1]
Certain prosthetic and orthotic devices	$0 (after deductible)	$0 (after plan deductible)
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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$0/$2,800 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$0/$2,800 HSA-Qualified Deductible HMO	Silver 70 HDHP HMO 2500/20%* + Child Dental
	MEMBER PAYS	MEMBER PAYS
ANNUAL PLAN DEDUCTIBLE Individual/Family	$2,800/$5,450 (embedded)	Self-only – $2,500 Individual – $2,800 Family – $5,000 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$4,500/$9,000 (embedded)	Individual – $6,850 Family – $13,700 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$0 (after deductible)	20% (after plan deductible)
Specialty office visits	$0 (after deductible)	20% (after plan deductible)
Urgent care visits	$0 (after deductible)	20% (after plan deductible)
Most laboratory tests	$0 (after deductible)	20% (after plan deductible)
Most X-rays and diagnostic testing	$0 (after deductible)	20% (after plan deductible)
Outpatient surgery per procedure	$250 (after deductible)	20% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	20% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	20% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$450 per day (after deductible; up to overall out-of-pocket maximum)	20% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	$0 (after deductible; base coverage only)[1]	20% (after plan deductible; base coverage, plus supplemental coverage up to $2,000 per year combined)[1]
Certain prosthetic and orthotic devices	$0 (after deductible)	$0 (after plan deductible)
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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$30/$3,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$3,000 HSA-Qualified Deductible HMO	Silver 70 HDHP HMO 2500/20%* + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$3,000/$6,000 (embedded)	Self-only – $2,500 Individual – $2,800 Family – $5,000 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$5,950/$11,900 (embedded)	Individual – $6,850 Family – $13,700 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30 (after deductible)	20% (after plan deductible)
Specialty office visits	$30 (after deductible)	20% (after plan deductible)
Urgent care visits	$30 (after deductible)	20% (after plan deductible)
Most laboratory tests	$10 (after deductible)	20% (after plan deductible)
Most X-rays and diagnostic testing	$10 (after deductible)	20% (after plan deductible)
Outpatient surgery per procedure	30% (after deductible)	20% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	20% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	20% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% per admission (after deductible; up to overall out-of-pocket maximum)	20% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	20% (after deductible; base coverage only)[1]	20% (after plan deductible; base coverage, plus supplemental coverage up to $2,000 per year combined)[1]
Certain prosthetic and orthotic devices	$0 (after deductible)	$0 (after plan deductible)
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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$30/$1,500 DEDUCTIBLE HMO PLAN WITH HRA

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$1,500 Deductible HMO with HRA	Gold 80 HRA HMO 2250/35[1] + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$1,500/$3,000 (embedded)	$2,250/$4,500 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000 (embedded)	$7,800/$15,600 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30 (after deductible)	$35
Specialty office visits	$30 (after deductible)	$50
Urgent care visits	$30 (after deductible)	$35
Most laboratory tests	$10 (after deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	$10 (after deductible)	25% (after plan deductible)
Outpatient surgery per procedure	20% (after deductible)	25% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$30 (after $100 drug deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after $100 drug deductible; up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% per admission (after deductible; up to overall out-of-pocket maximum)	25% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)[2]	50% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)[2]
Certain prosthetic and orthotic devices	$0	$0
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Groups 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 $100 to $400 per employee. If the group covers dependents, the allowable funding range per family is $200 to $800.

[2]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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Refer to the *Plan Highlights* brochure online at **kp.org/smallbusinessplans/ca** for more information and restrictions.

$30/$2,500 DEDUCTIBLE HMO PLAN WITH HRA

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$2,500 Deductible HMO with HRA	Gold 80 HRA HMO 2250/35[1] + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$2,500/$5,000 (embedded)	$2,250/$4,500 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$5,000/$10,000 (embedded)	$7,800/$15,600 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30 (after deductible)	$35
Specialty office visits	$30 (after deductible)	$50
Urgent care visits	$30 (after deductible)	$35
Most laboratory tests	$10 (after deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	$10 (after deductible)	25% (after plan deductible)
Outpatient surgery per procedure	20% (after deductible)	25% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$30 (after $100 drug deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after $100 drug deductible; up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% per admission (after deductible; up to overall out-of-pocket maximum)	25% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)[2]	50% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)[2]
Certain prosthetic and orthotic devices	$0	$0
Infertility	Not covered	Not covered
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Groups 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.

[2]Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

NOTES

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