Plan Highlights
Metal Plans

For effective dates January 1 to December 1, 2023

KAISER PERMANENTE®

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). The Kaiser Permanente PPO insurance plans are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. 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 insurance plan members receive child dental benefits as part of their coverage and not as a separate plan.
- This booklet is a summary 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 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 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 — great 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 office visits and prescriptions.

- Platinum 90 HMO 0/10 + Child Dental Alt[1]
- Platinum 90 HMO 0/20 + Child Dental
- Gold 80 HMO 0/30 + Child Dental Alt[1]

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 250/35 + Child Dental
- Gold 80 HMO 1000/40 + Child Dental Alt[1]
- Silver 70 HMO 1900/65 + Child Dental Alt[1]
- Silver 70 HMO 2300/65 + Child Dental Alt[1]
- Silver 70 HMO 2500/55 + Child Dental
- Silver 70 HMO 2800/65 + Child Dental Alt[1]
- Bronze 60 HMO 5400/60 + Child Dental Alt[1]
- 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 dollars[2] 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**. (Refer to page 4 for more details.)

- Gold 80 HDHP HMO 1600/15% + Child Dental Alt[1]
- Silver 70 HDHP HMO 2700/25% + Child Dental
- Bronze 60 HDHP HMO 7000/0 + 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 350/25 + Child Dental
- Silver 70 PPO 2500/55 + Child Dental
- Bronze 60 PPO 6300/65 + Child Dental

[1]The abbreviation "Alt," in certain plan names, designates Kaiser Permanente developed plans that are different from the standard plans and are available through Covered California for Small Business. These Alt plans also include chiro/acu benefits with the exception of the Gold 80 HDHP HMO 1600/15% plan.

[2]Tax 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.

HSAs

- 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 Gold 80 HDHP HMO 1600/15% + Child Dental Alt, Silver 70 HDHP HMO 2700/25% + Child Dental, or the Bronze 60 HDHP HMO 7000/0 + Child Dental benefit plans.[2]

HRAs[3]

- 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.

[1]Tax 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.

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

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

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 – $8,600[1,10] ③ Family – $17,200[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 per visit (after plan deductible)
Fertility 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 (up to a 30-day supply)	$18 (after $500 drug deductible)[24]
Brand-name drugs (up to a 30-day supply)	40% per prescription up to $500 maximum (after $500 drug deductible)[24]
Specialty drugs (up to a 30-day supply)	40% per prescription up to $500 maximum (after $500 drug deductible)[24]
HOSPITAL INPATIENT 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 Outpatient (in the medical office)	$0
Inpatient (in the hospital)	40% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$0
Inpatient (in the hospital) - detoxification only	40% (after plan deductible)
OTHER Televisits	$0
Acupuncture	$65 per visit (after plan deductible) for physician-referred acupuncture
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 17 for the plan footnotes.
Refer to page 18 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 60%, on average, members would be responsible for 40% 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 1/1/23–12/1/23
*Also available in Covered California for Small Business and CaliforniaChoice.

	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/20* + 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	$20
Urgent care visits	$10	$20
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 per visit	$5 per visit
Fertility services	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$10	$20
Most laboratory tests	$20	$20
Most X-rays and diagnostic testing	$40	$30
Most MRI/CT/PET scans	$150	$100
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 (up to a 30-day supply)	$5[24]	$5[24]
Brand-name drugs (up to a 30-day supply)	$15[24]	$20[24]
Specialty drugs (up to a 30-day supply)	10% per prescription up to $250 maximum[24]	10% per prescription up to $250 maximum[24]
HOSPITAL INPATIENT 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 Outpatient (in the medical office)	$10	$20
Inpatient (in the hospital)	$500 per admission	$250 per day up to 5 days per admission[26]
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$10	$20
Inpatient (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 (self-referral; 20 combined visits per year)	$20 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 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

Kaiser Permanente Gold HMO plans

Plan Highlights

For effective dates 1/1/23–12/1/23
*Also available in Covered California for Small Business and CaliforniaChoice.

	Gold 80 HMO 0/30* + Child Dental Alt	Gold 80 HMO 250/35* + Child Dental
FEATURES	**Copay HMO Plan**	**Deductible HMO Plan**
PLAN DEDUCTIBLE Embedded	$0	Individual – $250[10] Family – $500[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,500[1,28] Family – $15,000[1,28]	Individual – $7,800[1,10] Family – $15,600[1,10]
IN THE MEDICAL OFFICE Primary care visits	$30	$35
Urgent care visits	$30	$35
Specialty office visits	$50	$55
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 per visit	$5 per visit
Fertility services	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$30	$35
Most laboratory tests	$30	$35
Most X-rays and diagnostic testing	$40	$55
Most MRI/CT/PET scans	$250	$250 (after plan deductible)
Outpatient surgery (per procedure)	$320	$335 (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	$250	$250 (after plan deductible)
Ambulance	$250	$250 (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$15[24]	$15[24]
Brand-name drugs (up to a 30-day supply)	$50[24]	$40[24]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum[24]	20% per prescription up to $250 maximum[24]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission[26]	$600 per day up to 5 days per admission (after plan deductible)[26]
Skilled nursing facility care (up to 100 days per benefit period)	$300 per day up to 5 days per admission[26]	$300 per day up to 5 days per admission (after plan deductible)[26]
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$30	$35
Inpatient (in the hospital)	$600 per day up to 5 days per admission[26]	$600 per day up to 5 days per admission (after plan deductible)[26]
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$30	$35
Inpatient (in the hospital) - detoxification only	$600 per day up to 5 days per admission[26]	$600 per day up to 5 days per admission (after plan deductible)[26]
OTHER Televisits	$0	$0
Chiropractic and acupuncture	$15 per visit (self-referral; 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]	20%[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	$30 per visit
Hospice care	$0	$0

Refer to page 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

Kaiser Permanente Gold HMO plans

Plan Highlights

For effective dates 1/1/23–12/1/23
*Also available in Covered California for Small Business and CaliforniaChoice.

	Gold 80 HMO 1000/40* + Child Dental Alt	Gold 80 HDHP HMO 1600/15%* + Child Dental Alt	Gold 80 HRA HMO 2250/35 + Child Dental
FEATURES	**Deductible HMO Plan**	**HSA-Qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)**	**Deductible HMO with HRA Plan[30] (HRA can be administered through Kaiser Permanente)**
PLAN DEDUCTIBLE Embedded	Individual – $1,000[10] Family – $2,000[10]	Self-only – $1,600[10,32] Individual – $3,000[10,32] Family – $3,200[10,32]	Individual – $2,250[10] Family – $4,500[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,800[1,10] Family – $15,600[1,10]	Individual – $3,550[10,29] Family – $7,100[10,29]	Individual – $8,500[1,10] Family – $17,000[1,10]
IN THE MEDICAL OFFICE Primary care visits	$40	15% (after plan deductible)	$35
Urgent care visits	$40	15% (after plan deductible)	$35
Specialty office visits	$60	15% (after plan deductible)	$50
Preventive exams, vaccines (immunizations)	$0[12]	$0[12]	$0[12]
Prenatal care	$0[3]	$0[4]	$0[3]
Postpartum care	$0[3]	$0 (after plan deductible)[16]	$0[3]
Well-child preventive care visits	$0[23]	$0[23]	$0[23]
Allergy injections	$5 per visit	15% per visit (after plan deductible)	$5 per visit (after plan deductible)
Fertility services	Not covered[17]	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$40	15% (after plan deductible)	$35 (after plan deductible)
Most laboratory tests	$30	15% (after plan deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	$60	15% (after plan deductible)	25% (after plan deductible)
Most MRI/CT/PET scans	$350 (after plan deductible)	15% (after plan deductible)	25% (after plan deductible)
Outpatient surgery (per procedure)	$350	15% (after plan deductible)	25% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	$350	15% (after plan deductible)	25% (after plan deductible)
Ambulance	$350	15% (after plan deductible)	25% (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$20[24]	$15 (after plan deductible)[24]	$15[24]
Brand-name drugs (up to a 30-day supply)	$50 (after $250 drug deductible)[24]	$45 (after plan deductible)[24]	$30 (after $100 drug deductible)[24]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after $250 drug deductible)[24]	15% per prescription up to $250 maximum (after plan deductible)[24]	20% per prescription up to $250 maximum (after $100 drug deductible)[24]
HOSPITAL INPATIENT 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]	15% (after plan deductible)	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]	15% (after plan deductible)	25% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$40	15% (after plan deductible)	$35
Inpatient (in the hospital)	$600 per day up to 5 days per admission (after plan deductible)[26]	15% (after plan deductible)	25% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$40	15% (after plan deductible)	$35
Inpatient (in the hospital) - detoxification only	$600 per day up to 5 days per admission (after plan deductible)[26]	15% (after plan deductible)	25% (after plan deductible)
OTHER Televisits	$0	$0 (after plan deductible) [33]	$0
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	15% per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered	$35 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (supplemental and base)	20%[5,6,27]	15% (after plan deductible)[5,6]	50%[5,6,27]
Certain prosthetic and orthotic devices	$0	$0 (after plan deductible)	$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)	$0	15% (after plan deductible)	$0
Hospice care	$0	$0 (after plan deductible)	$0

Refer to page 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

Refer to page 4 for HRA details.

Kaiser Permanente Silver HMO plans

Plan Highlights

For effective dates 1/1/23–12/1/23
*Also available in Covered California for Small Business and CaliforniaChoice.

	Silver 70 HMO 1900/65* + Child Dental Alt	Silver 70 HMO 2300/65* + Child Dental Alt	Silver 70 HMO 2500/55* + Child Dental
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**	**Deductible HMO Plan**
PLAN DEDUCTIBLE Embedded	Individual – $1,900[10] Family – $3,800[10]	Individual – $2,300[10] Family – $4,600[10]	Individual – $2,500[10] Family – $5,000[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $8,750[1,10] Family – $17,500[1,10]	Individual – $8,750[1,10] Family – $17,500[1,10]	Individual – $8,750[1,10] Family – $17,500[1,10]
IN THE MEDICAL OFFICE Primary care visits	$65	$65	$55
Urgent care visits	$65	$65	$55
Specialty office visits	$100	$100	$90
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 per visit	$5 per visit	$5 per visit
Fertility services	Not covered[17]	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$65	$65	$55
Most laboratory tests	$30	$30	$55
Most X-rays and diagnostic testing	$75	$75	$90
Most MRI/CT/PET scans	$400 (after plan deductible)	$400 (after plan deductible)	$300 (after plan deductible)
Outpatient surgery (per procedure)	45% (after plan deductible)	45% (after plan deductible)	35% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	45% (after plan deductible)	45% (after plan deductible)	30% (after plan deductible)
Ambulance	45% (after plan deductible)	45% (after plan deductible)	30% (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$20[24]	$20[24]	$19[24]
Brand-name drugs (up to a 30-day supply)	$100[24]	$100 (after $500 drug deductible)[24]	$85 (after $370 drug deductible)[24]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after plan deductible)[24]	20% per prescription up to $250 maximum (after $500 drug deductible)[24]	30% per prescription up to $250 maximum (after $370 drug deductible)[24]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	45% (after plan deductible)	45% (after plan deductible)	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	45% (after plan deductible)	45% (after plan deductible)	40% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$0	$0	$0
Inpatient (in the hospital)	45% (after plan deductible)	45% (after plan deductible)	40% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$0	$0	$0
Inpatient (in the hospital) - detoxification only	45% (after plan deductible)	45% (after plan deductible)	40% (after plan deductible)
OTHER Televisits	$0	$0	$0
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	$15 per visit (self-referral; 20 combined visits per year)	$55 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (supplemental and base)	45%[5,6,27]	45%[5,6,27]	40%[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)	$0	$0	$45 per visit
Hospice care	$0	$0	$0

Refer to page 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

Kaiser Permanente Silver HMO plans

Plan Highlights

For effective dates 1/1/23–12/1/23
*Also available in Covered California for Small Business and CaliforniaChoice.

	Silver 70 HMO 2800/65* + Child Dental Alt	Silver 70 HDHP HMO 2700/25%* + Child Dental
FEATURES	**Deductible HMO Plan**	**HSA-Qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)**
PLAN DEDUCTIBLE Embedded	Individual – $2,800[10] Family – $5,600[10]	Self-only – $2,700[10,32] Individual – $3,000[10,32] Family – $5,400[10,32]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $8750[1,10] Family – $17,500[1,10]	Individual – $7,200[10,29] Family – $14,400[10,29]
IN THE MEDICAL OFFICE Primary care visits	$65	25% (after plan deductible)
Urgent care visits	$65	25% (after plan deductible)
Specialty office visits	$100	25% (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 per visit	25% per visit (after plan deductible)
Fertility services	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$65	25% (after plan deductible)
Most laboratory tests	$30 (after plan deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	$75 (after plan deductible)	25% (after plan deductible)
Most MRI/CT/PET scans	$400 (after plan deductible)	25% (after plan deductible)
Outpatient surgery (per procedure)	45% (after plan deductible)	25% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	45% (after plan deductible)	25% (after plan deductible)
Ambulance	45% (after plan deductible)	25% (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$20[24]	25% per prescription up to $250 maximum (after plan deductible)[24]
Brand-name drugs (up to a 30-day supply)	$100 (after plan deductible)[24]	25% per prescription up to $250 maximum (after plan deductible)[24]
Specialty drugs (up to a 30-day supply)	45% per prescription up to $250 maximum (after plan deductible)[24]	25% per prescription up to $250 maximum (after plan deductible)[24]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	45% (after plan deductible)	25% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	45% (after plan deductible)	25% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$0	$0 (after plan deductible)
Inpatient (in the hospital)	45% (after plan deductible)	25% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$0	$0 (after plan deductible)
Inpatient (in the hospital) - detoxification only	45% (after plan deductible)	25% (after plan deductible)
OTHER Televisits	$0	$0 (after plan deductible)[33]
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	25% per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (supplemental and base)	45%[5,6,27]	25% (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)	$0	25% (after plan deductible)
Hospice care	$0	$0 (after plan deductible)

Refer to page 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

Refer to page 4 for HSA details.

Kaiser Permanente Bronze HMO plans

Plan Highlights

For effective dates 1/1/23–12/1/23
*Also available in Covered California for Small Business and CaliforniaChoice.

	Bronze 60 HMO 5400/60* + Child Dental Alt	Bronze 60 HMO 6300/65* + Child Dental	Bronze 60 HDHP HMO 7000/0* + Child Dental
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**	**HSA-Qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)**
PLAN DEDUCTIBLE Embedded	Individual – $5,400[10] Family – $10,800[10]	Individual – $6,300[10] Family – $12,600[10]	Individual – $7,000[10] Family – $14,000[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $8,300[1,10] Family – $16,600[1,10]	Individual – $8,600[1,10] Family – $17,200[1,10]	Individual – $7,000[10,29] Family – $14,000[10,29]
IN THE MEDICAL OFFICE			
Primary care visits	$60 (after plan deductible)[2]	$65 (after plan deductible)[2]	$0 (after plan deductible)
Urgent care visits	$60 (after plan deductible)[2]	$65 (after plan deductible)[2]	$0 (after plan deductible)
Specialty office visits	$80 (after plan deductible)[2]	$95 (after plan deductible)[2]	$0 (after plan deductible)
Preventive exams, vaccines (immunizations)	$0[12]	$0[12]	$0[12]
Prenatal care	$0[3]	$0[3]	$0[4]
Postpartum care	$0[3]	$0[3]	$0 (after plan deductible)[16]
Well-child preventive care visits	$0[23]	$0[23]	$0[23]
Allergy injections	$5 per visit (after plan deductible)	$5 per visit (after plan deductible)	$0 per visit (after plan deductible)
Fertility services	Not covered[17]	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$65	$65	$0 (after plan deductible)
Most laboratory tests	$30 (after plan deductible)	$40	$0 (after plan deductible)
Most X-rays and diagnostic testing	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
Most MRI/CT/PET scans	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
Outpatient surgery (per procedure)	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
Ambulance	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$20[24]	$18 (after $500 drug deductible)[24]	$0 (after plan deductible)[24]
Brand-name drugs (up to a 30-day supply)	50% per prescription up to $500 maximum (after plan deductible)[24]	40% per prescription up to $500 maximum (after $500 drug deductible)[24]	$0 (after plan deductible)[24]
Specialty drugs (up to a 30-day supply)	50% per prescription up to $500 maximum (after plan deductible)[24]	40% per prescription up to $500 maximum (after $500 drug deductible)[24]	$0 (after plan deductible)[24]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
MENTAL HEALTH SERVICES			
Outpatient (in the medical office)	$0 (after plan deductible)[2]	$0	$0 (after plan deductible)
Inpatient (in the hospital)	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
SUBSTANCE USE DISORDER SERVICES			
Outpatient (in the medical office)	$0 (after plan deductible)[2]	$0	$0 (after plan deductible)
Inpatient (in the hospital) - detoxification only	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
OTHER Televisits	$0	$0	$0 (after plan deductible)[33]
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	$65 per visit (after plan deductible) 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)	50% (after plan deductible)[5,6]	40% (after plan deductible)[5,6]	$0 (after plan deductible)[5,6]
Certain prosthetic and orthotic devices	$0	$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]	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)	50% (after plan deductible)	40% (after plan deductible)	$0 (after plan deductible)
Hospice care	$0	$0	$0 (after plan deductible)

Refer to page 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

Refer to page 4 for HSA details.

KPIC Platinum PPO insurance plans

For effective dates 1/1/23–12/1/23

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% per visit	30% per visit (after plan deductible)
Fertility 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)	$200	$200
Ambulance	$150	$150
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$10[18,19]	
Brand-name drugs (up to a 30-day supply)	$25[18,19]	
Specialty drugs (up to a 30-day supply)	10% per prescription up to $250 maximum[19]	
HOSPITAL INPATIENT 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 Outpatient (in the medical office)	$15	30% (after plan deductible)
Inpatient (in the hospital)	10%	30% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$15	30% (after plan deductible)
Inpatient (in the hospital) - detoxification only	10%	30% (after plan deductible)
OTHER Televisits	$0	$0
Acupuncture	$15 per visit	30% per visit (after plan deductible)
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 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

KPIC Gold PPO insurance plans

For effective dates 1/1/23–12/1/23

Plan Highlights

	Gold 80 PPO 350/25 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[9]**	**Non-Participating Provider Tier (out-of-network)[9]**
PLAN DEDUCTIBLE Embedded	Individual – $350[10] Family – $700[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% per visit	40% per visit (after plan deductible)
Fertility 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)	20% (after plan deductible)	20% (after plan deductible)
Ambulance	20% (after plan deductible)	20% (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$15[18,19]	
Brand-name drugs (up to a 30-day supply)	$50[18,19]	
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum[19]	
HOSPITAL INPATIENT 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 Outpatient (in the medical office)	$25	40% (after plan deductible)
Inpatient (in the hospital)	20% (after plan deductible)	40% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES In the medical office	$25	40% (after plan deductible)
Inpatient (in the hospital) - detoxification only	20% (after plan deductible)	40% (after plan deductible)
OTHER Televisits	$0	$0
Acupuncture	$25 per visit	40% per visit (after plan deductible)
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 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

KPIC Silver PPO insurance plans

For effective dates 1/1/23–12/1/23

Plan Highlights

	Silver 70 PPO 2500/55 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[9]**	**Non-Participating Provider Tier (out-of-network)[9]**
PLAN DEDUCTIBLE Embedded	Individual – $2,500[10] Family – $5,000[10]	Individual – $5,000[10] Family – $10,000[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $8,750[10,11] Family – $17,500[10,11]	Individual – $17,500[10,11] Family – $35,000[10,11]
IN THE MEDICAL OFFICE Primary care visits	$55	40% (after plan deductible)
Urgent care visits	$55	40% (after plan deductible)
Specialty office visits	$90	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% per visit	40% per visit (after plan deductible)
Fertility services	50% (after plan deductible)[15]	Not covered
Physical, occupational, and speech therapy	$55	40% (after plan deductible)
Most laboratory tests	$55	40% (after plan deductible)
Most X-rays and diagnostic testing	$90	40% (after plan deductible)
Most MRI/CT/PET scans	$300 (after plan deductible)	40% (after plan deductible)
Outpatient surgery (per procedure)	35% (after plan deductible)	50% (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	30% (after plan deductible)	30% (after plan deductible)
Ambulance	30% (after plan deductible)	30% (after plan deductible)
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$19[18,19]	
Brand-name drugs (up to a 30-day supply)	$85 (after $300 drug deductible)[18,19]	
Specialty drugs (up to a 30-day supply)	30% per prescription up to $250 maximum (after $300 drug deductible)[19]	
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible)	50% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	40% (after plan deductible)	50% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$55	40% (after plan deductible)
Inpatient (in the hospital)	40% (after plan deductible)	50% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$55	40% (after plan deductible)
Inpatient (in the hospital) - detoxification only	40% (after plan deductible)	50% (after plan deductible)
OTHER Televisits	$0	$0
Acupuncture	$55 per visit	40% per visit (after plan deductible)
Certain durable medical equipment (DME) (supplemental and base)	40%[21,22]	40% (after plan deductible)[21,22]
Certain prosthetic and orthotic devices	30%	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 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

KPIC Bronze PPO insurance plans

For effective dates 1/1/23–12/1/23

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 – $8,200[10,11] Family – $16,400[10.11]	Individual – $16,400[10,11] Family – $32,800[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	40% per visit	100% per visit (up to out-of-pocket maximum)[20]
Fertility 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 (up to a 30-day supply)	$18 (after $500 drug deductible)[18,19]	
Brand-name drugs (up to a 30-day supply)	40% per prescription up to $500 maximum (after $500 drug deductible)[18,19]	
Specialty drugs (up to a 30-day supply)	40% per prescription up to $500 maximum (after $500 drug deductible)[19]	
HOSPITAL INPATIENT 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 Outpatient (in the medical office)	$65 (after plan deductible)[2]	100% (up to out-of-pocket maximum)[20]
Inpatient (in the hospital)	40% (after plan deductible)	100% (up to out-of-pocket maximum)[20]
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$65 (after plan deductible)[2]	100% (up to out-of-pocket maximum)[20]
Inpatient (in the hospital) - detoxification only	40% (after plan deductible)	100% (up to out-of-pocket maximum)[20]
OTHER Televisits	$0	$0
Acupuncture	$65 per visit (after plan deductible)	100% per visit (up to out-of-pocket maximum)[20]
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 17 for the plan footnotes.

Refer to page 18 for the child dental benefits.

Footnotes for 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.

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

[2]**Deductible 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.

[3]Scheduled prenatal visits and postpartum visits.

[4]Scheduled prenatal visits.

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

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

[7]Under age 19. One pair of eyeglasses from a limited selection.

[8]Kaiser 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.

[9]Payments 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.

[10]This 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.

[11]Covered 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*.

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

[13]Routine 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.

[14]Delivery 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*.

[15]Benefits 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.

[16]First postpartum visit only, covered at no charge.

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

[18]Insured 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.

[19]Your 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.

[20]Even 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.

[21]Both 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.

[22]Diabetic 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.

[23]Well-child visits through age 23 months.

[24]Prescription drugs are covered in accordance with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copays. For information on our formulary, including the drugs on the specialty tier, go to **kp.org/formulary** or call our Member Service Contact Center.

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

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

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

[28]This 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.

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

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

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

[32]Self-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.

[33]For 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%

[1]The child dental benefits are embedded into all metal PPO medical plans.
[2]No separate child dental OOP maximum – applied to medical OOP maximum
[3]Orthodontics includes medically necessary orthodontia only.

Supplemental family dental plans

These plans are administered by Delta Dental of California, one of the nation's largest and most experienced dental benefits providers. On the following pages, choose from a variety of dental plans, which you can pair with any of our medical plans for greater flexibility and access.

DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

Kaiser Permanente Insurance Company (KPIC) Fee-for-Service (Premier) dental plans

For effective dates 1/1/23–12/1/23

These dental insurance plans are underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California. The plans below aren't intended to satisfy the ACA child dental benefits.

	PLAN C	PLAN D	PLAN E	PLAN E WITH ORTHO
SERVICE	Plan Pays*	Plan Pays*	Plan Pays*	Plan Pays*
NO DEDUCTIBLE APPLIES TO THESE PROCEDURES.				
EXAM – Twice a year	100%	100%	100%	100%
BITEWING X-RAYS – Twice a year For children through age 18, or once a year for adults ages 19 and over	100%	100%	100%	100%
OTHER X-RAYS Full-mouth X-rays, single X-rays, and panographic X-rays once in any 5-year period	80%	80%	80%	80%
PROPHYLAXIS (CLEANING) A cleaning twice a year to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	100%	100%	100%
FLUORIDE Only for children through age 18, twice a year	100%	100%	100%	100%
SPACE MAINTAINERS	100%	100%	100%	100%
DEDUCTIBLES APPLY TO PROCEDURES UNDER PLANS D, E, AND E WITH ORTHODONTICS.				
DEDUCTIBLE Per person, per year, up to a family maximum of $75 per year	No deductible	$25	$25	$25
BENEFIT MAXIMUM The benefit maximum represents the total amount paid by the plan per person, per year	$500	$1,000	$1,000	$1,000
DENTAL IMPLANTS	Not covered	Not covered	Not covered	Not covered
DENTURE RELINES – Twice a year	Not covered	80%	80%	80%
FILLINGS	80%	80%	80%	80%
STAINLESS STEEL CROWNS Primary teeth only	80%	80%	80%	80%
ENDODONTICS A dental specialty concerned with treatment of the root and nerve of the tooth	Not covered	80%	80%	80%
PERIODONTICS A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	Not covered	80%	80%	80%
ORAL SURGERY	Not covered	80%	80%	80%
CROWNS AND CAST RESTORATIONS Includes replacements after 5 years, but only if originally covered by KPIC dental plan	Not covered	Not covered	50%	50%
PROSTHODONTICS Standard removable prosthetic appliance (includes replacements after 5 years, but only if originally covered by KPIC dental plan)	Not covered	Not covered	50%	50%
ORTHODONTICS For eligible dependent children through age 18, $1,500 lifetime maximum per insured (Replacement or repair of an orthodontic appliance paid for in part or in full by this plan isn't covered.)	Not covered	Not covered	Not covered	50%

*Benefits payable will be based on the lesser of the prevailing fee or the submitted amount fee.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Insurance Company (KPIC) PPO dental plans

For effective dates 1/1/23–12/1/23

These dental insurance plans are underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California. The plans below aren't intended to satisfy the ACA child dental benefits.

	PPO AG 1500		PPO AH 2000		PPO D 1500		PPO E 1000		PPO E 1500	
SERVICE	Plan Pays[1] (PPO Network)	Plan Pays[1,2] (Out-of-Network)	Plan Pays[1] (PPO Network)	Plan Pays[1,2] (Out-of-Network)	Plan Pays (PPO + Premier Network)	Plan Pays[2] (Out-of-Network)	Plan Pays (PPO + Premier Network)	Plan Pays[2] (Out-of-Network)	Plan Pays (PPO + Premier Network)	Plan Pays[2] (Out-of-Network)
NO DEDUCTIBLE APPLIES TO THESE PROCEDURES.										
EXAM – Twice a year	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
BITEWING X-RAYS – Twice a year For children through age 18, or once a year for adults ages 19 and over	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
OTHER X-RAYS Full-mouth X-rays, single X-rays, and panographic X-rays once in any 5-year period	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
PROPHYLAXIS (cleaning) A cleaning twice a year to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
FLUORIDE Only for children through age 18, twice a year	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
SPACE MAINTAINERS	100%	90%	100%	90%	100%	50%	100%	50%	100%	50%
DEDUCTIBLES APPLY TO PROCEDURES BELOW.										
DEDUCTIBLE	$50	$50	$50	$50	$25	$50	$25	$50	$25	$50
BENEFIT MAXIMUM The benefit maximum represents the total amount paid by the plan per person, per year	$1,500		$2,000		$1,500		$1,000		$1,500	
DENTAL IMPLANTS	Not covered	Not covered	50%	50%	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
DENTURE RELINES – Twice a year	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
FILLINGS	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
STAINLESS STEEL CROWNS – Primary teeth only	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
ENDODONTICS A dental specialty concerned with treatment of the root and nerve of the tooth	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
PERIODONTICS A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
ORAL SURGERY	80%	70%	80%	70%	80%	50%	80%	50%	80%	50%
CROWNS AND CAST RESTORATIONS Includes replacements after 5 years, but only if originally covered by KPIC dental plan	50%	50%	50%	50%	Not covered	Not covered	50%	50%	50%	50%
PROSTHODONTICS Standard removable prosthetic appliance (includes replacements after 5 years, but only if originally covered by KPIC dental plan)	50%	50%	50%	50%	Not covered	Not covered	50%	50%	50%	50%
ORTHODONTICS For eligible dependent children through age 18, $1,500 lifetime maximum per insured (Replacement or repair of an orthodontic appliance paid for in part or in full by this plan isn't covered.)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

[1]Reimbursement for all dentists will be based on the PPO provider contracted fee.
[2]Benefits payable will be based on the lesser of the prevailing fee or the submitted amount fee.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

DeltaCare HMO dental plans

For effective dates 1/1/23–12/1/23

DeltaCare USA is underwritten and administered by Delta Dental of California. The plans below aren't intended to satisfy the ACA child dental benefits.

	DELTACARE 10A	DELTACARE 13B
SERVICES	**Member Pays**	**Member Pays**
PREVENTIVE CARE – Twice a year Periodic and comprehensive – oral evaluation	No cost	No cost
Bitewing X-rays – Twice a year For children through age 18, or once a year for adults ages 19 and over	No cost	No cost
Prophylaxis – Twice a year	No cost	No cost
Fluoride treatments Only for children up to age 19, twice a year	No cost	No cost
Space maintainers Removable – unilateral	$10	$50
PERIODONTICS – Twice a year Maintenance	No cost	$35
Scaling and root planing Limited to 4 quadrants per year	No cost	$50
Surgery – osseous (includes flap entry and closure) 4 or more teeth per quadrant	$175	$300
RESTORATIVE – 4 or more surfaces Fillings – primary or permanent amalgam	No cost	No cost
Composite crowns – resin-based Anterior	No cost	$55
Crown – porcelain	$195	$355
Inlay – metallic 1 surface	No cost	$145
ENDODONTICS Therapeutic pulpotomy Excludes final restoration	No cost	$25
Root amputation – Per root	No cost	$70
Root canal – anterior Excludes final restoration	$45	$95
Root canal – molar Excludes final restoration	$205	$335
PROSTHODONTICS – Complete denture The enrollee must continue to be eligible, and the service must be provided at the contract dentist facility where the denture was originally delivered.	$100	$285
Reline maxillary or mandibular denture – chairside Complete or partial	No cost	$50
Reline maxillary or mandibular denture – laboratory Complete or partial	$35	$85
ORAL AND MAXILLOFACIAL SURGERY Extraction – erupted tooth or exposed root Elevation and/or forceps removal	No cost	$5
Surgical removal of erupted tooth Complete or partial	$15	$45
ORTHODONTICS Comprehensive orthodontic Child or adolescent to age 19	$1,700	$1,900
Comprehensive orthodontic Adults, including covered dependent adult children	$1,900	$2,100

Benefits listed above are only a sample of provided services and associated costs. Costs will vary. Please see the *Evidence of Coverage* for a comprehensive list of all services and costs. DeltaCare benefits are only covered when performed by an in-network California DeltaCare HMO provider. In California, DeltaCare USA is underwritten and administered by Delta Dental of California.

DELTA DENTAL®

KAISER PERMANENTE®

Exclusions for the KPIC Fee-for-Service (Premier) and KPIC PPO dental plans

The KPIC Fee-for-Service (Premier) and PPO dental insurance plans aren't intended to satisfy the ACA child dental benefits.

The following services aren't covered under any Kaiser Permanente Insurance Company (KPIC) group dental insurance plans:

- Cosmetic surgery, dentistry, or services to correct hereditary, congenital, or developmental malformations
- Restoration of tooth structure crowns, and/or cast restorations, or chewing surfaces for damages due to wear
- Prosthodontic services or procedures started prior to a person's date of eligibility.
- Prescribed drugs medication, painkillers, antimicrobial agents, or experimental/investigational procedures
- Anesthesia (except general anesthesia for oral surgery).
- Services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal, or other associated procedures. Doesn't apply to the PPO AH 2000.
- Treatment related to the temporomandibular joint (TMJ).
- Orthodontic treatment, except for eligible dependent children under Plan E with Orthodontics.
- Treatment plans that are higher level of services than those customarily provided under accepted dental practice or specialized techniques used instead of standard procedures; for example, a precision denture where a standard denture would suffice.
- Replacement of existing restoration for any purpose other than active tooth decay.
- Intravenous sedation, occlusal guards, or complete occlusal adjustment.

Predetermination of benefits is recommended for services in excess of $300. This document isn't intended as a summary plan description, nor is it designed to serve as the *Certificate of Insurance* or the *Schedule of Coverage*. It contains only a summary of benefits, exclusions, and limitations.

If you have specific questions regarding benefit structure, limitations, or exclusions, consult the *Certificate of Insurance* and the *Schedule of Coverage* or contact Delta Dental's Customer Service Department at **800-835-2244**, 8 a.m. to 5 p.m., Monday through Friday.

For a list of in-network providers, contact Delta Dental's Customer Service Department or visit **deltadentalins.com**.

This dental insurance plan is underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Exclusions of benefits for the DeltaCare HMO dental plans

The DeltaCare HMO plans aren't intended to satisfy the ACA child dental benefits.

- The DeltaCare HMO dental plan isn't available for employees enrolled in a PPO medical plan and living outside of California.
- Any procedure that in the professional opinion of the contract dentist:
  - has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
  - is inconsistent with generally accepted standards for dentistry.
- Services solely for cosmetic purposes, with the exception of procedure D9972 (external bleaching, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
- Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns, and fixed partial dentures (bridges) for children under 16 years of age.
- Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns, and fixed partial dentures (bridges).
- Procedures, appliances, or restoration, if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
- Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith), and personalization and characterization of complete and partial dentures.
- Implant-supported dental appliances and attachments; implant placement, maintenance, or removal; and all other services associated with a dental implant.
- Consultations for noncovered benefits.
- Dental services received from any dental facility other than the assigned contract dentist, a preauthorized dental specialist, or a contract orthodontist except for Emergency Services as described in the contract and/or *Evidence of Coverage*.
- All related fees for admission, use, or stays in a hospital, outpatient surgery center, extended care facility, or other similar care facility.
- Prescription drugs.
- Dental expenses incurred in connection with any dental or orthodontic procedure started before the enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken, and orthodontics unless qualified for the orthodontic treatment in progress provision.
- Lost, stolen, or broken orthodontic appliances.
- Changes in orthodontic treatment necessitated by accident of any kind.
- Myofunctional and parafunctional appliances and/or therapies.
- Composite or ceramic brackets, lingual adaptation of orthodontic bands, and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
- Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services.

For additional benefit information or a directory of Delta dentists, please call Delta Dental at 800-422-4234 or visit deltadentalins.com.

DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

KAISER PERMANENTE®

Chiropractic and acupuncture*

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

Medically necessary chiropractic services are covered when provided by a participating chiropractor to diagnose or treat musculoskeletal and related disorders. Medically necessary acupuncture services are covered when provided by a participating acupuncturist to diagnose or treat musculoskeletal and related 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 participating providers except for the initial examination, emergency and urgent chiropractic and acupuncture services, and services that aren't available from ASH participating providers or other licensed providers with which ASH contracts to provide covered care. **You can obtain an initial examination from any ASH participating provider without a referral from a Kaiser Permanente plan physician.** Each office visit counts toward any visit limit, if applicable.

X-rays and laboratory tests: Medically necessary X-rays and laboratory tests are covered, at no charge, when prescribed as part of covered chiropractic care and an ASH participating provider provides the services or refers you to another licensed provider that ASH contracts for the services.

Emergency services: Covered chiropractic services provided for the treatment of a musculoskeletal and related disorder which results in acute symptoms of sufficient severity (including severe pain) in which the absence of immediate chiropractic services would result in serious jeopardy to your health, body functions, or organs.

Covered acupuncture services provided for the treatment of a musculoskeletal and related disorder, nausea, or pain, which results in acute symptoms of sufficient severity (including severe pain) in which the absence of immediate acupuncture services results in serious jeopardy to your health, body functions, or organs.

Participating chiropractors and acupuncturists

ASH Plans contracts with ASH participating providers and other licensed providers that provide covered chiropractic services and covered acupuncture services. You must receive these services from an ASH participating provider or another licensed provider that ASH contracts; except for emergency chiropractic services, emergency acupuncture services, urgent chiropractic services, urgent acupuncture services, services that aren't available from contracted providers, and services that are authorized in advance by ASH Plans. The list of ASH participating providers is available on the ASH Plans website at **ashlink.com/ash/kaisercamedicare** for Kaiser Permanente Senior Advantage members, **ashlink.com/ash/kp** for all other members, or from the ASH Plans Customer Service Department at **800-678-9133** (TTY **711**). The list of ASH participating providers is subject to change, at any time, without notice.

How to obtain covered services

To obtain covered services, call an ASH participating provider to schedule an initial examination. If services are required, verification that the services are medically necessary may be required. Your ASH participating provider will request any medical treatment necessary. An ASH Plans clinician, in the same or similar specialty as the provider of services under review, will decide whether the services are or were medically necessary. ASH Plans will disclose to you, upon request, the written criteria it uses to make the decision to authorize, modify, delay, or deny a request for authorization. If you have questions or concerns, contact the ASH Plans Customer Service 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*.

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

- Platinum 90 HMO 0/10 + Child Dental Alt
- Gold 80 HMO 0/30 + Child Dental Alt
- Gold 80 HMO 1000/40 + Child Dental Alt
- Silver 70 HMO 1900/65 + Child Dental Alt
- Silver 70 HMO 2300/65 + Child Dental Alt
- Silver 70 HMO 2800/65 + Child Dental Alt
- Bronze 60 HMO 5400/60 + Child Dental Alt

American Specialty Health Plans of California

KAISER PERMANENTE®

Durable medical equipment (DME) benefits

Home therapeutic benefits which are provided to patients with certain medical conditions and/or illnesses.

All Kaiser Permanente small group metal plans cover both "base" DME items that are a part of the essential health benefits and "supplemental" DME items that aren't a part of the essential health benefits.

Supplemental DME benefits are subject to a $2,000 annual benefit maximum

Below is a sample list of DME covered items.*

BASE DME COVERAGE

- Blood glucose monitor and supplies
- Bone stimulator
- Canes and crutches
- Cervical traction (over door)
- Dry pressure pad
- Infusion pumps and supplies
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets

SUPPLEMENTAL DME COVERAGE

- Oxygen tanks
- CPAP (continuous positive airway pressure)
- Wheelchairs
- Hospital beds

*If you're located outside of a Kaiser Permanente area, some DME items may not be covered. For more detailed DME benefit information, including cost shares, benefit maximums, and limitations, please refer to your *Combined Disclosure Form and Evidence of Coverage* or *Certificate of Insurance*.

Pediatric vision care

(Services only rendered at Kaiser Permanente for Kaiser Permanente Vision Essentials)

Affordable Care Act (ACA)–qualified health plans include vision benefits and medical care from trusted Kaiser Permanente optometrists and ophthalmologists. You can connect vision care to overall health with Vision Essentials by Kaiser Permanente. Because our optometrists and ophthalmologists work with our integrated care system, they're connected to our larger team of medical professionals. Regular eye exams can detect not only vision problems but also symptoms of other important health issues.

Services must be performed and provided by a Kaiser Permanente provider for children who are under the age of 19 and are covered under an ACA metal plan. They'll have their choice of either regular clear eyeglasses or contact lenses from the Value Collection to serve their vision needs.

FEATURES	MEMBER PAYS
ROUTINE VISION EXAM[1]	$0
EYEGLASS OPTION[2]	
Yearly eye exam with refraction	$0
Regular clear eyeglasses (Value Collection frame and lenses only)	$0
CONTACT LENS OPTION[3]	
Yearly eye exam with refraction	$0
Contact lens fitting fees	$0
One pair of standard or disposable contact lenses	$0

[1]Schedule a routine eye exam with a plan optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses **(not subject to the plan deductible)**.

[2]If you prefer to wear eyeglasses rather than contact lenses, we cover one complete pair of eyeglasses (frame and regular eyeglass lenses) from our designated value frame collection **(not subject to the plan deductible)** every 12 months when prescribed by a physician or optometrist and a plan provider puts the lenses into an eyeglass frame.

[3]If you prefer to wear contact lenses rather than eyeglasses, we cover one of the following, including fitting and dispensing, **(not subject to the plan deductible)** when prescribed by a physician or optometrist and obtained at a plan medical office or plan optical sales office:
- Standard contact lenses: one pair of lenses in any 12-month period
- Disposable contact lenses: one 6-month supply for each eye in any 12-month period

Important Information
To find locations, products, and services for metal plans, go to **kp2020.org**.
For further detailed information on pediatric vision, refer to your *Combined Disclosure Form and Evidence of Coverage*.

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Notes

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