A BETTER WAY TO TAKE CARE OF BUSINESS

2024 Small business | California

A better way to take care of your employees and your business

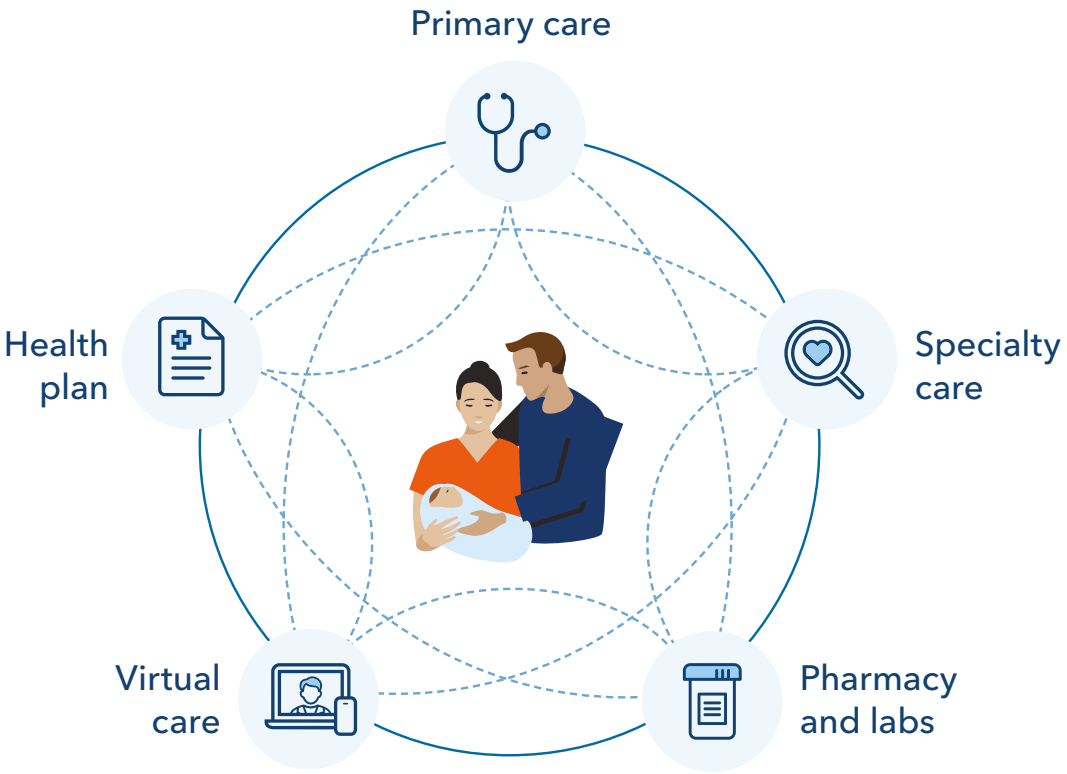
kp.org/choosebetter | California

KAISER PERMANENTE®

Discover the Kaiser Permanente difference

To successfully manage your total costs and improve business performance, you need a partner who addresses the health of your employees early, consistently, and effectively.

A truly integrated care model



At Kaiser Permanente, you get a different approach

Your employees won't get treated only when they're sick or injured. Our integrated care model brings together coverage, care, hospitals, labs, and pharmacies to provide the convenient, proactive care needed to help keep your employees healthier. It also helps ensure you get a simple administrative experience, with a comprehensive mix of benefits, plans, and supplemental options to provide maximum value for your investment.

"My doctor was completely informed about my past records, covered all my questions, and advised me as to what needs to be done next, as far as lab tests, etc., go. I was completely satisfied with my virtual appointment."

– **Carole**, Kaiser Permanente member

High-quality virtual care for a wide range of health needs

Your employees can get the care they want, how they want it – helping them stay healthier and more engaged on the job.

Surging satisfaction

Members rate our video visits 4.4 out of 5 stars, and 89% were interested in future video visits.[1]

Significant outcomes

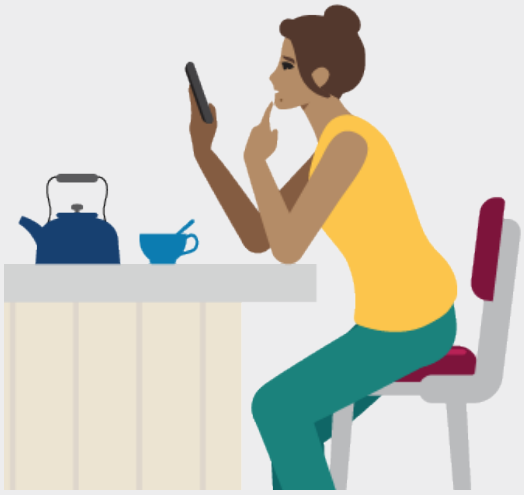
15% better outcomes

62% fewer home health visits

for total joint replacement patients who participated in Kaiser Permanente's virtual patient education and home exercise pilot program prior to surgery.[3]

As effective as in-person care

Members who had virtual primary care didn't seek more follow-up care than those who had in-person visits.[2]



Give your employees a fully integrated virtual experience

Virtual and in-person care are connected through electronic health records, accessible online at kp.org or by using our mobile app.

Members have online access to:

- 24/7 care by phone or video
- Information about past visits
- Appointment scheduling
- Emailing their doctor's office

Why it matters

Each in-person appointment your employees don't need saves you an average of 2 hours of work time.[4]

1. Kaiser Permanente internal data, August 2021. **2.** Reed et al., JAMA Network Open, November 16, 2021. **3.** See note 2. **4.** Rhyan, Altarum, February 22, 2019.

Why choose Kaiser Permanente?

Cost-effective care

With Kaiser Permanente, your workforce will get timely screenings and vaccinations, all at no cost or at a copay only, helping your employees avoid unnecessary tests and procedures now – and costly diagnostic care in the future. We make it easy to get started, with an array of plan designs and price points to fit your budget.

Time-saving convenience

When care is convenient, your employees are more likely to get the services they need to stay healthy. Telehealth care options such as phone appointments, email consultations, and video visits make it easy for your employees to connect with Kaiser Permanente care teams. And when members need in-person care, we make that easy, too. In fact, members can often see their doctor, visit a specialist, get lab tests, and pick up prescriptions all in one trip.

Industry-leading quality

Our top-notch doctors have developed a distinct brand of evidence-based care we call Permanente Medicine. It's a team-based, patient-centered approach to total health that focuses on delivering the right care – not more care. That includes personalized, consistent care at every touch point, from screenings and prevention to chronic disease management and specialty care – helping to keep your employees healthier and more engaged.

Number one health plan in America[1]

insure.com

One of the world's most ethical companies 4 years in a row.[2]

ETHISPHERE®
GOOD. SMART. BUSINESS. PROFIT.®

Top-rated health plans in California – 7 years in a row.[3]

National Committee for Quality Assurance

1. "Best Health Insurance Companies of 2023," Insure.com, January 23, 2023. **2.** "The 2022 World's Most Ethical Companies® Honoree List," Ethisphere.com, March 15, 2022. **3.** NCQA's Private Health Insurance Plan Ratings 2022–2023, National Committee for Quality Assurance, 2022: Kaiser Foundation Health Plan, Inc., of Northern California – HMO (rated 4.5 out of 5); Kaiser Foundation Health Plan, Inc., of Southern California – HMO (rated 4.5 out of 5). NCQA's Private Health Insurance Plan Ratings 2015–2022, National Committee for Quality Assurance.

Health care that's easy to navigate

Your employees get built-in support to access care and prioritize health at a better value for your business.

Access is simple from day one

Our new-member onboarding program guides your employees with personalized videos and a welcome site so they can quickly transfer prescriptions, find a doctor, and start getting care. When an employee visits most of our facilities, they can see their doctor, get a lab test, and go to the pharmacy in one stop.

Care is proactive and personalized

Your employee partners with their doctor to create a care plan, including industry-leading prevention based on their individual risk factors. When your employee is due for care or needs to refill a prescription, their care team lets them know. To keep their health on track, we'll share convenient wellness resources such as local classes and farmers markets. Plus, members get reduced rates on gym memberships, massage therapy, wearable fitness devices, and more.

Digital tools help track care and coverage

Your employees will have easy access to digital tools that can give them a clear picture of their care options, as well as how to pay for care and coverage. This includes deductible and out-of-pocket cost trackers so your employees can see how close they are to meeting their maximums. They can also get personalized cost estimates for medical services and prescriptions on kp.org.

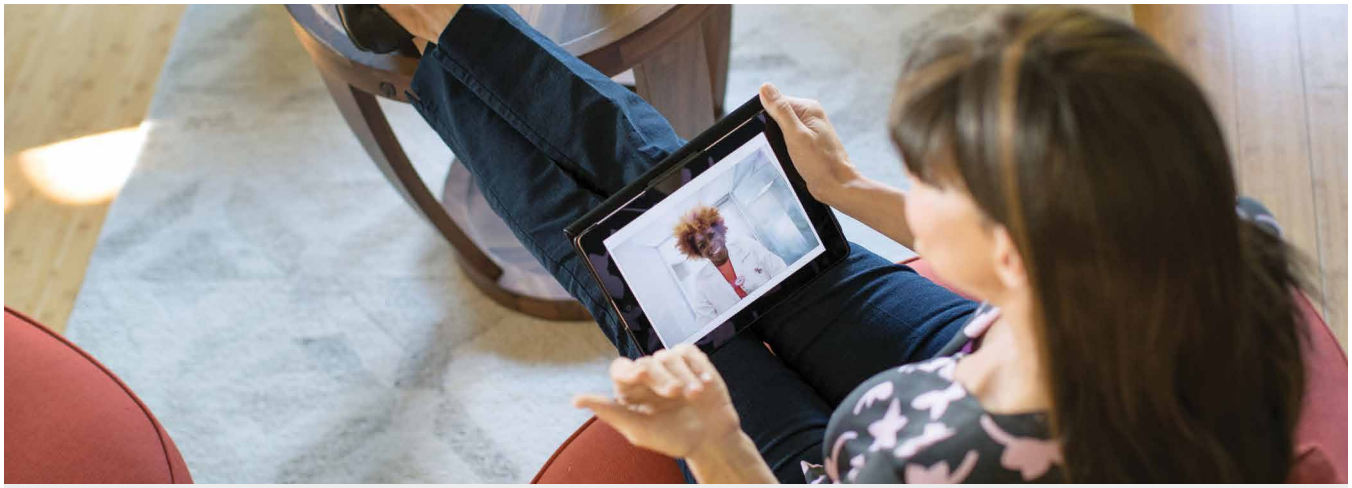
Even better, some care doesn't need an estimate. Preventive care is always available at no cost, with no copay.

Convenient support to help manage chronic conditions

Chronic health conditions are a significant drain on the health and engagement of your workforce. That's why we build chronic condition management into your coverage. When members are at risk of or diagnosed with a chronic condition, they're automatically enrolled in a disease management program. **No opt-in needed.**

That means you don't have to deal with – or pay for – third-party disease management vendors. And your employees get a seamless and convenient experience from their Kaiser Permanente care team. Disease management programs help members address health issues such as:

- Asthma and other lung issues
- Chronic pain
- Depression
- Diabetes
- Heart disease
- High blood pressure
- Smoking
- Weight management



We protect businesses from the high cost of hypertension.[1]

Kaiser Permanente blood pressure control rate:	72%
National average for blood pressure control:	60%

Why it matters

Medical costs are $7,418 higher for employees with hypertension.[2]

1. Kaiser Permanente 2022 HEDIS® scores. **2.** Peterson-KFF Health System Tracker, 2021.

Leading the way for mental health

When you partner with Kaiser Permanente, you'll be connected to our full suite of mental health resources for your workforce. And your employees will get the care, access, and tools that are most important to them, including:

- **Personalized care plans:** Individual or group therapy, wellness coaching, and more – all tailored to your employees' needs and goals.
- **More doctors in more places:** We're hiring more mental health professionals to support the growing need we see in our communities. Plus, you don't need a referral to access mental health services from a Kaiser Permanente provider.
- **On-demand support:** 24/7 advice, online health assessments, telehealth services, and self-care tools available when your employees need them.
- **Expanded capabilities:** Demand for virtual mental health care has risen dramatically – during the pandemic, we shifted more than 90% of our mental health visits to virtual care.

Patient feedback shows members are happy with their mental health care*

94%
of members feel their care team respects what they have to say

93%
satisfaction with video visits

90%
satisfaction with phone appointments

*Internal Kaiser Permanente data

When your employees travel, our coverage follows

The last thing your employees want to worry about as they get back to business trips and family vacations is their health coverage. Now, it's easier than ever for them to get care if something unexpected happens while they're away from home.

In the U.S.

Within Kaiser Permanente service areas, members can get routine, urgent, and emergency care at our facilities. Or they can get 24/7 care by phone or video. Members can also get emergency and urgent care anywhere they need it. At many locations outside Kaiser Permanente states (Cigna Healthcare℠ PPO Network* providers, MinuteClinic locations and pharmacies, Concentra clinics, and The Little Clinic), they'll just pay their usual cost share.

Internationally

Members can get emergency and urgent care around the world.

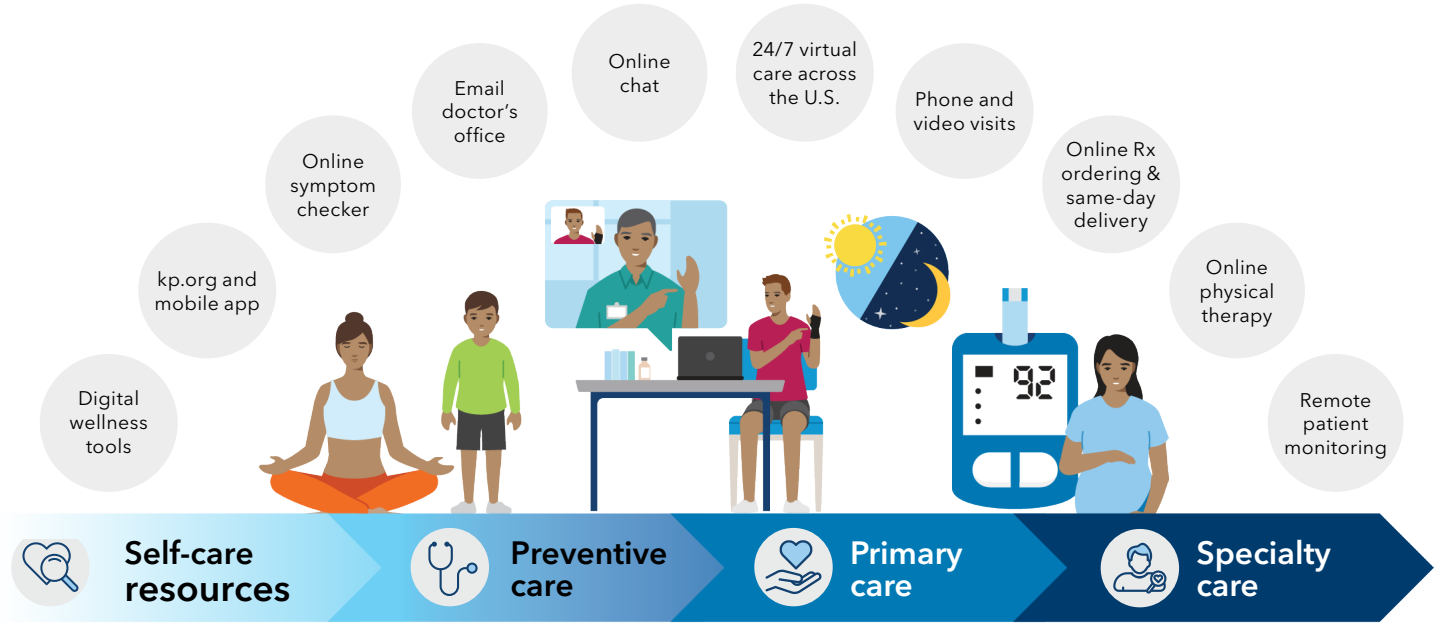
*The Cigna Healthcare℠ PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

Cigna Healthcare℠ is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Intellectual Property, Inc.

Good health, virtually anywhere

We make it easy to connect to care quickly and conveniently. Your employees can skip the drive and save time with phone appointments, video visits, e-visits, and email consultations – plus 24/7 virtual care and advice.

Wellness tools are always at your employees' fingertips: They can use kp.org and the Kaiser Permanente app to schedule routine appointments, fill most prescriptions, and view most lab results. Plus, in-facility video conferencing gets more doctors in the exam room for faster, more coordinated care.



Keep good health within reach

Employees who actively take care of their health are more likely to stay at their jobs and cost their employers less for their health care. Improve your wellness strategy with tools from Kaiser Permanente that are designed to address specific risks relevant to your workforce.

Healthy lifestyle programs

Online programs offering tools for healthy living and personalized tips to help employees reach their health goals.

classpass

Your employees get no-cost access to thousands of on-demand workout videos with ClassPass. Plus, free trials and reduced rates on ClassPass membership to in-person exercise classes from top studios worldwide.

Wellness apps[1,2]

An app for meditation, mindfulness, mental resilience, and sleep – designed to help lower stress, anxiety, and more.

Calm

Text one-on-one with an emotional support coach anytime, anywhere. Support is just a text message away.[3]

Headspace Care

Build a personalized plan to strengthen your emotional health whenever, wherever you need to.

myStrength

1. The apps and services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. The apps and services may be discontinued at any time. **2.** Calm and myStrength can be used by members 13 and over. The Headspace Care app and services are not available to any members under 18 years old. **3.** Eligible Kaiser Permanente members can text with a coach using the Headspace Care app for 90 days per year. After the 90 days, members can continue to access the other services available on the Headspace Care app for the remainder of the year at no cost.

Across California, we have over 500 medical facilities and 17,500 doctors available to our members.

And we're producing recognized results for our members.

Care delivery

Top-rated health plans in California – 7 years in a row[1]

Of the 24 commercial health plans in California rated by the National Committee for Quality Assurance, our plans are the top-rated in the state for the seventh year in a row.

Quality of care

Best in state for behavioral and mental health care[2]

In the 2022–23 edition of the California Office of the Patient Advocate's Health Care Quality Report Card, Kaiser Permanente's behavioral and mental health care in Northern and Southern California scored a perfect 5 stars – making our plans the highest-rated in the state and the only ones to receive "Excellent" ratings.

Quality of care

Leading California in 74 effectiveness-of-care measures[3]

In 2022, Kaiser Permanente led the state as the top performer in 74 HEDIS® (Healthcare Effectiveness Data and Information Set) effectiveness-of-care measures – the most of any health plan.

Chart a healthier future for your workforce.
Contact your Kaiser Permanente representative to learn how.

1. NCQA's Private Health Insurance Plan Ratings 2022–2023, National Committee for Quality Assurance, 2022: Kaiser Foundation Health Plan, Inc., of Northern California – HMO (rated 4.5 out of 5); Kaiser Foundation Health Plan, Inc., of Southern California – HMO (rated 4.5 out of 5). NCQA's Private Health Insurance Plan Ratings 2015–2022, National Committee for Quality Assurance. **2.** Health Care Quality Report Card, 2022–23, California Office of the Patient Advocate. 2022–23 edition results are based on 2021 performance data. View the complete report at reportcard.opa.ca.gov. **3.** Kaiser Permanente 2022 HEDIS® scores. Benchmarks provided by the National Committee for Quality Assurance (NCQA) Quality Compass® and represent all lines of business. Kaiser Permanente combined region scores were provided by the Kaiser Permanente Department of Care and Service Quality. The source for data contained in this publication is Quality Compass 2022 and is used with the permission of NCQA. Quality Compass 2022 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® and HEDIS® are registered trademarks of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

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KAISER PERMANENTE®

1197244509 January 2024

2024 SMALL BUSINESS | CALIFORNIA

Plan Highlights
Metal Plans

For effective dates January 1 to December 1, 2024

KAISER PERMANENTE®

What's inside

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

This is a summary of benefits only and is subject to change. The KFHP *Evidence of Coverage* and the KPIC *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided isn't intended to describe all the benefits included in each plan, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.

Your plan options

When it comes to health care, you expect plans that are simple and easy to use – for you and 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.

All HMO plans are also offered at Covered California for Small Business and *CaliforniaChoice*® (except Gold 80 HRA HMO 2250/35+ Child Dental).

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†
- Platinum 90 HMO 0/20* + Child Dental
- Gold 80 HMO 0/35* + Child Dental Alt†

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.

- Platinum 90 HMO 250/30* + Child Dental Alt†
- Gold 80 HMO 250/35* + Child Dental
- 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 2500/55* + Child Dental
- Silver 70 HMO 2950/65* + Child Dental Alt†
- Bronze 60 HMO 5400/60* + Child Dental Alt†
- Bronze 60 HMO 6300/60* + 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, 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. 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 $3.25 administrative fee per employee account can be paid by you or your employees.

- Gold 80 HDHP HMO 1750/15%* + Child Dental Alt†
- Silver 70 HDHP HMO 2850/25%* + Child Dental
- Bronze 60 HDHP HMO 7050/0%* + 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. An HRA lets you contribute money for your employees to use to pay qualified medical expenses on a tax-free basis.[1,2] A monthly $3.75 administrative fee per employee account is paid by you, the employer.

- Gold 80 HRA HMO 2250/35 + Child Dental[3]

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 HRA come with a health payment card, which works just like a debit card, so employees don't have to submit claims or file for reimbursement when paying qualified medical expenses using their card.
- Plus, our HRA offers employees the convenience of automatic reimbursement for eligible medical services received and paid for at Kaiser Permanente facilities.

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.

PPO insurance plans – You and you employees get flexibility and choice of doctors from any licensed provider in the country, and are free to see a specialist without a referral. Choose from any participating provider nationwide with the Private Health Care Systems (PHCS) Network for KPIC in California and other Kaiser Permanente states (Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and the District of Columbia). In all other states, visits a Cigna Healthcare PPO Network provider. For more information, call 800-788-0710, Monday through Friday 7 a.m. to 7 p.m. Or visit kp.org/kpic/ppo, to find providers and other materials

- Platinum 90 PPO 0/15 + Child Dental
- Gold 80 PPO 350/25 + Child Dental
- Silver 70 PPO 2500/55 + Child Dental
- Bronze 60 PPO 6300/60 + Child Dental

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

Supplemental family dental plans (optional)

- Our supplemental family dental plans cover adults and dependent children up to age 26, when dependent coverage is offered. These plans do not substitute for the ACA required child dental coverage for members under 19 years old.
- Family dental plans are available only to those enrolled in a Kaiser Permanente health plan.
- If you choose to offer a family dental plan, all subscribers and dependents must participate.
- The DeltaCare HMO family dental plan isn't offered with any PPO health plans

Chiropractic and acupuncture

- Combined coverage for chiropractic/acupuncture care is included in most ACA-compliant metal ALT plans, except for Gold 80 HDHP HMO 1750/15% + Child Dental ALT.
- Grandfathered (nonmetal) plans (OPTIONAL)
  - The optional combined chiropractic/acupuncture coverage is available for grandfathered (nonmetal) plans for an added cost. This option is not available for the grandfathered HSA-qualified high deductible health plans (HDHP).
  - If you choose to offer chiropractic/acupuncture coverage, all subscribers and dependents must participate.
  - You can only add this coverage at renewal and can discontinue coverage anytime up to 4 months before your renewal date or at renewal.

Fertility benefit (optional)

- The optional fertility benefit is available for an added cost and only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier.
- Metal plans
- Upon selection of this optional benefit, it will be added to all the HMO plans offered, as part of the original contract, or can be added or discontinued upon renewal.
- Fertility benefit is already included in all metal PPO plans.
- Grandfathered (nonmetal) plans
- This option is available to existing groups with grandfathered (nonmetal) plans and added only at renewal
- Coverage will be added to all grandfathered (nonmetal) HMO plans offered, except the $5 and $15 copay plans, as fertility is already embedded, and the cost is included in the plan rate.

* The plan is also offered at Covered California for Small Business and CaliforniaChoice®.

† 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.

1. Refer to IRS Publication 502 for a list of qualified medical and dental expenses. **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. **3.** Groups selecting the Gold 80 HRA HMO 2250/35 + Child Dental plan must establish and fund an HRA for each enrolled employee. The allowable funding range is $100 to $400 per employee and $200 to $800 per family, if the group covers dependents.

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.

FEATURES	Bronze 60 (1) HMO 6300/60* + Child Dental Copay HMO Plan Member Pays
PLAN DEDUCTIBLE (Embedded) (2)	Individual – 6,300[10] / Family – 12,600[10] (3)
OUT-OF-POCKET MAXIMUM (Embedded) (4)	Individual – 9,100[10] / Family – 18,200[10]
IN THE MEDICAL OFFICE Primary care visits	$60
Urgent care visits	$60
Specialty office visits	$95 (after plan deductible)
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0[12] (5)
Well-child preventive care visits	$0[23] through age 23 months
Fertility services	Not covered (may be added to this plan for an additional cost)[17]
Physical, occupational, and speech therapy	$60
Most laboratory tests	$40 (6)
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 (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	 $17 (after $500/$1,000 drug deductible) [8,9] 40% per prescription up to $500 maximum (after $500/$1,000 drug deductible) [8,9] 40% per prescription up to $500 maximum (after $500/$1,000 drug deductible) [8,9]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after plan deductible) (7)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$0
Inpatient (in the hospital)	45% (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$0
Inpatient (in the hospital) - detoxification only	40% (after plan deductible)

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

For effective dates 1/1/24–12/1/24

FEATURES	Platinum 90 HMO 0/10* + Child Dental Alt† Copay HMO Plan Member Pays	Platinum 90 HMO 0/20* + Child Dental Alt† Copay HMO Plan Member Pays	Platinum 90 HMO 250/30* + Child Dental Alt† Deductible HMO Plan Member Pays
PLAN DEDUCTIBLE (Embedded)	$0	$0	Individual – $250 / Family – $500
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $3,000[1,3] / Family – $6,000[1,3]	Individual – $4,500[1,3] / Family – $9,000[1,3]	Individual – $3,000[2,3]/ Family – $6,000[2,3]
IN THE MEDICAL OFFICE Primary care visits	$10	$20	$30
Urgent care visits	$10	$20	$30
Specialty office visits	$20	$30	$50
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0[4,5]	$0[4,5]	$0[4,5]
Well-child preventive care visits	$0 through age 23 months	$0 through age 23 months	$0 through age 23 months
Fertility services	Not covered[6]	Not covered[6]	Not covered[6]
Physical, occupational, and speech therapy	$10	$20	$30
Most laboratory tests	$20[7]	$20[7]	$30[7]
Most X-rays and diagnostic testing	$40[7]	$30[7]	$50[7]
Most MRI / CT / PET scans	$150[7]	$100[7]	$150[7]
Outpatient surgery (per procedure)	$300	$125	$300
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	$200	$150	$250
Ambulance	$150	$150	$150
PRESCRIPTIONS (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	$5[8,9] $15[8,9] 10% per prescription up to $250 maximum [8,9]	$5[8,9] $20[8,9] 10% per prescription up to $250 maximum[8,9]	$10[8,9] $20[8,9] 10% per prescription up to $250 maximum (after plan deductible)[8,9]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per admission	$250 per day per admission[11]	$500 per admission (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$10	$20	$30
Inpatient (in the hospital)	$500 per admission	$250 per day per admission[11]	$500 per admission (after plan deductible)
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$10	$20	$30
Inpatient (in the hospital) - detoxification only	$500 per admission	$250 per day per admission[11]	$500 per admission (after plan deductible)
OTHER Virtual care	$0	$0	$0
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	$20 per visit for physician-referred acupuncture only	$15 per visit (self-referral; 20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	10%[10]	10%[10]	10%[10]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[12]	1 pair of eyeglasses or contact lenses per year[12]	1 pair of eyeglasses or contact lenses per year[12]
Pediatric vision exam	$0	$0	$0
Adult optical (eyewear)	$175 allowance[13]	Not covered[14]	Not covered[14]
Adult vision exam (for eye refraction)	$0	$0	$0

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Gold HMO plans

For effective dates 1/1/24–12/1/24

	Gold 80 HMO 0/35* + Child Dental Alt†	Gold 80 HMO 250/35* + Child Dental
FEATURES	**Copay HMO Plan Member Pays**	**Copay HMO Plan Member Pays**
PLAN DEDUCTIBLE (Embedded)	$0	Individual – $250 [2] / Family – $500 [2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $7,700 [1,3] / Family – $15,400 [1,3]	Individual – $7,800 [2,3] / Family – $15,600 [2,3]
IN THE MEDICAL OFFICE Primary care visits	$35	$35
Urgent care visits	$35	$35
Specialty office visits	$60	$55
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0 [4,5]	$0 [4,5]
Well-child preventive care visits	$0 through age 23 months	$0 through age 23 months
Fertility services	Not covered [6]	Not covered [6]
Physical, occupational, and speech therapy	$35	$35
Most laboratory tests	$30 [7]	$35 [7]
Most X-rays and diagnostic testing	$40 [7]	$55 [7]
Most MRI / CT / PET scans	$250 [7]	$250 (after plan deductible) [7]
Outpatient surgery (per procedure)	$320	$335 (after plan deductible)
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	$350	$250 (after plan deductible)
Ambulance	$250	$250 (after plan deductible)
PRESCRIPTIONS (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	 $15 [8,9] $50 [8,9] 20% per prescription up to $250 maximum [8,9]	 $15 [8,9] $40 [8,9] 20% per prescription up to $250 maximum [8,9]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission [11]	$600 per day up to 5 days per admission (after plan deductible) [11]
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$35	$35
Inpatient (in the hospital)	$600 per day up to 5 days per admission [11]	$600 per day up to 5 days per admission (after plan deductible) [11]
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$35	$35
Inpatient (in the hospital) - detoxification only	$600 per day up to 5 days per admission [11]	$600 per day up to 5 days per admission (after plan deductible) [11]
OTHER Virtual care	$0	$0
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	$35 per visit for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	20% [10]	20% [10]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year [12]	1 pair of eyeglasses or contact lenses per year [12]
Pediatric vision exam	$0	$0
Adult optical (eyewear)	Not covered [14]	Not covered [14]
Adult vision exam (for eye refraction)	$0	$0

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Gold HMO plans

For effective dates 1/1/24–12/1/24

FEATURES	Gold 80 HMO 1000/40* + Child Dental Alt†	Gold 80 HDHP HMO 1750/15%* + Child Dental Alt†	Gold 80 HRA HMO 2250/35 + Child Dental
	Deductible HMO Plan Member Pays	HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)	Deductible HMO with HRA Plan[16] (HRA can be administered through Kaiser Permanente)
PLAN DEDUCTIBLE (Embedded)	Individual – $1,000 [2] / Family – $2,000 [2]	Self-only – $1,750 [2,15] / Individual – $3,200 [2,15] / Family – $3,500 [2,15]	Individual – $2,250 [2] / Family – $4,500 [2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $7,800 [2,3] / Family – $15,600 [2,3]	Individual – $3,700 [2,3] / Family – $7,400 [2,3]	Individual – $8,500 [2,3] / Family – $17,000 [2,3]
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 services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0 [4,5]	$0 [4,5]	$0 [4,5]
Well-child preventive care visits	$0 through age 23 months	$0 through age 23 months	$0 through age 23 months
Fertility services	Not covered [6]	Not covered [6]	Not covered [6]
Physical, occupational, and speech therapy	$40	15% (after plan deductible)	$35 (after plan deductible)
Most laboratory tests	$30 [7]	15% (after plan deductible) [7]	25% (after plan deductible) [7]
Most X-rays and diagnostic testing	$60 [7]	15% (after plan deductible) [7]	25% (after plan deductible) [7]
Most MRI / CT / PET scans	$350 (after plan deductible) [7]	15% (after plan deductible) [7]	25% (after plan deductible) [7]
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 (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	$20 [8,9] $50 (after $250/$500 drug deductible) [8,9,19] 20% per prescription up to $250 maximum (after $250/$500 drug deductible) [8,9,19]	$15 (after plan deductible) [8,9] $45 (after plan deductible) [8,9] 15% up to $250 maximum (after plan deductible) [8,9]	$15 [8,9] $30 (after $100/$200 drug deductible) [8,9,18] 20% per prescription up to $250 maximum (after $100/$200 drug deductible) [8,9,18]
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) [11]	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) [11]	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) [11]	15% (after plan deductible)	25% (after plan deductible)
OTHER Virtual care	$0	$0 (after plan deductible) [17]	$0
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	15% per visit after deductible for physician-referred acupuncture only	25% per visit after deductible for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	20% [10]	15% [10]	50% [10]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year [12]	1 pair of eyeglasses or contact lenses per year [12]	1 pair of eyeglasses or contact lenses per year [12]
Pediatric vision exam	$0	$0	$0
Adult optical (eyewear)	Not covered [14]	Not covered [14]	Not covered [14]
Adult vision exam (for eye refraction)	$0	$0	$0

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Silver HMO plans

For effective dates 1/1/24–12/1/24

FEATURES	Silver 70 HMO 1900/65* + Child Dental Alt† Deductible HMO Plan Member Pays	Silver 70 HMO 2300/65* + Child Dental Alt† Deductible HMO Plan Member Pays	Silver 70 HMO 2500/55* + Child Dental Deductible HMO Plan Member Pays
PLAN DEDUCTIBLE (Embedded)	Individual – $1,900[2] / Family – $3,800[2]	Individual – $2,300[2] / Family – $4,600[2]	Individual – $2,500[2] / Family – $5,000[2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $8,750[2,3] / Family – $17,500[2,3]	Individual – $8,750[2,3] / Family – $17,500[2,3]	Individual – $8,750[2,3] / Family – $17,500[2,3]
IN THE MEDICAL OFFICE Primary care visits	$65	$65	$55
Urgent care visits	$65	$65	$55
Specialty office visits	$100	$100	$90
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0[4,5]	$0[4,5]	$0[4,5]
Well-child preventive care visits	$0 through age 23 months	$0 through age 23 months	$0 through age 23 months
Fertility services	Not covered[6]	Not covered[6]	Not covered[6]
Physical, occupational, and speech therapy	$65	$65	$55
Most laboratory tests	$30[7]	$30[7]	$55[7]
Most X-rays and diagnostic testing	$75[7]	$75[7]	$90[7]
Most MRI / CT / PET scans	$400 (after plan deductible)[7]	$400 (after plan deductible)[7]	$300 (after plan deductible)[7]
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)	35% (after plan deductible)
Ambulance	45% (after plan deductible)	45% (after plan deductible)	35% (after plan deductible)
PRESCRIPTIONS (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	$20[8,9] $100[8,9] 20% per prescription up to $250 maximum (after plan deductible)[8,9]	$20[8,9] $100 (after $500/$1,000 drug deductible)[8,9,21] 20% per prescription up to $250 maximum (after $500/$1,000 drug deductible)[8,9,21]	$19[8,9] $85 (after $300/$600 drug deductible)[8,9,20] 30% per prescription (after $300/$600 drug deductible)[8,9,20]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	45% (after plan deductible)	45% (after plan deductible)	35% (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)	35% (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)	35% (after plan deductible)
OTHER Virtual care	$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 only
Certain durable medical equipment (DME) (supplemental and base)	45%[10]	45%[10]	35%[10]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[12]	1 pair of eyeglasses or contact lenses per year[12]	1 pair of eyeglasses or contact lenses per year[12]
Pediatric vision exam	$0	$0	$0
Adult optical (eyewear)	Not covered[14]	Not covered[14]	Not covered[14]
Adult vision exam (for eye refraction)	$0	$0	$0

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Silver HMO plans

For effective dates 1/1/24–12/1/24

FEATURES	Silver 70 HMO 2950/65* + Child Dental Alt†	Silver 70 HDHP HMO 2850/25%* + Child Dental
	Deductible HMO Plan Member Pays	HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)
PLAN DEDUCTIBLE (Embedded)	Individual – $2,950 [2] / Family – $5,900 [2]	Self-only – $2,850 [2,15] / Individual – $3,200 [2,15] / Family – $5,700 [2,15]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $9,100 [2,3] / Family – $18,200 [2,3]	Individual $7,500 [2,3] / Family $15,000 [2,3]
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 services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0 [4,5]	$0 [4,5]
Well-child preventive care visits	$0 through age 23 months	$0 through age 23 months
Fertility services	Not covered [6]	Not covered [6]
Physical, occupational, and speech therapy	$65	25% (after plan deductible)
Most laboratory tests	$30 (after plan deductible) [7]	25% (after plan deductible) [7]
Most X-rays and diagnostic testing	$75 (after plan deductible) [7]	25% (after plan deductible) [7]
Most MRI / CT / PET scans	$400 (after plan deductible) [7]	25% (after plan deductible) [7]
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 (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	 $20 [8,9] $100 (after plan deductible) [8,9] 45% per prescription up to $250 maximum (after plan deductible) [8,9]	 25% per prescription up to $250 maximum (after plan deductible) [8] 25% per prescription up to $250 maximum (after plan deductible) [8] 25% per prescription up to $250 maximum (after plan deductible) [8]
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	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 Virtual care	$0	$0 (after plan deductible) [17]
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	25% per visit after deductible for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	45% [10]	25% [10]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year [12]	1 pair of eyeglasses or conact lenses per year [12]
Pediatric vision exam	$0	$0
Adult optical (eyewear)	Not covered [14]	Not covered [14]
Adult vision exam (for eye refraction)	$0	$0

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Bronze HMO plans

For effective dates 1/1/24–12/1/24

FEATURES	Bronze 60 HMO 5400/60* + Child Dental Alt†	Bronze 60 HMO 6300/60* + Child Dental	Bronze 60 HDHP HMO 7050/0%* + Child Dental
	Deductible HMO Plan Member Pays	Deductible HMO Plan Member Pays	HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)
PLAN DEDUCTIBLE (Embedded)	Individual – $5,400 [2] / Family – $10,800 [2]	Individual – $6,300 [2] / Family – $12,600 [2]	Individual – $7,050 [2] / Family – $14,100 [2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $8,600 [2,3] / Family – $17,200 [2,3]	Individual – $9,100 [2,3] / Family – $18,200 [2,3]	Individual – $7,050 [2,3] / Family – $14,100 [2,3]
IN THE MEDICAL OFFICE Primary care visits	$60 (after plan deductible) [22]	$60 (after plan deductible) [22]	0% (after plan deductible)
Urgent care visits	$60 (after plan deductible) [22]	$60 (after plan deductible) [22]	0% (after plan deductible)
Specialty office visits	$80 (after plan deductible) [22]	$95 (after plan deductible) [22]	0% (after plan deductible)
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0 [4,5]	$0 [4,5]	$0 [4,5]
Well-child preventive care visits	$0 through age 23 months	$0 through age 23 months	$0 through age 23 months
Fertility services	Not covered [6]	Not covered [6]	Not covered [6]
Physical, occupational, and speech therapy	$65	$60	0% (after plan deductible)
Most laboratory tests	$30 (after plan deductible) [7]	$40 [7]	0% (after plan deductible) [7]
Most X-rays and diagnostic testing	50% (after plan deductible) [7]	40% (after plan deductible) [7]	0% (after plan deductible) [7]
Most MRI / CT / PET scans	50% (after plan deductible) [7]	40% (after plan deductible) [7]	0% (after plan deductible) [7]
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 (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	$20 [8,9] 50% per prescription up to $500 maximum (after plan deductible) [8,9] 50% per prescription up to $500 maximum (after plan deductible) [8,9]	$17 (after $500/$1,000 drug deductible) [8,9,21] 40% per prescription up to $500 maximum (after $500/$1,000 drug deductible) [8,9,21] 40% per prescription up to $500 maximum (after $500/$1,000 drug deductible) [8,9,21]	0% (after plan deductible) [8,9] 0% (after plan deductible) [8,9] 0% per prescription (after plan deductible) [8,9]
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)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$0 (after plan deductible) [22]	$0 [22]	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) [22]	$0 [22]	0% (after plan deductible)
Inpatient (in the hospital) - detoxification only	50% (after plan deductible)	40% (after plan deductible)	0% (after plan deductible)
OTHER Virtual care	$0	$0	$0 (after plan deductible) [17]
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)	$60 per visit for physician-referred acupuncture only	0% per visit after deductible for physician-referred acupuncture only
Certain durable medical equipment (DME) (supplemental and base)	50% (after plan deductible) [10]	40% (after plan deductible) [10]	0% (after plan deductible) [10]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year [12]	1 pair of eyeglasses or contact lenses per year [12]	1 pair of eyeglasses or contact lenses per year [12]
Pediatric vision exam	$0	$0	$0
Adult optical (eyewear)	Not covered [14]	Not covered [14]	Not covered [14]
Adult vision exam (for eye refraction)	$0	$0	$0

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

KPIC Platinum PPO insurance

For effective dates 1/1/24–12/1/24

	Platinum 90 PPO 0/15 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[23]**	**Non-Participating Provider Tier (out-of-network)[23]**
PLAN DEDUCTIBLE (Embedded)	$0	Individual – $500[2] / Family – $1,000[2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $4,500[24] / Family – $9,000[24]	Individual – $9,000[2,24] / Family – $18,000[2,24]
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 services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0[4,5,25,26]	30%[4,5,25,26]
Well-child preventive care visits	$0 through age 23 months	30% through age 23 months
Fertility services	50%[27]	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 (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	 $10[9,28,29] $25[9,28,29] 10% per prescription up to $250 maximum[9,29]	 Not Covered Not Covered Not Covered
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	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 Virtual care	$0	$0
Acupuncture (physician referred)	$15 per visit	30% (after plan deductible)
Certain durable medical equipment (DME) (supplemental and base)	10%[10,30]	30% (after plan deductible)[10,30]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[12]	10% (after plan deductible)[12]
Pediatric vision exam	$0	0% (after plan deductible)
Adult optical (eyewear)	Not covered	Not Covered
Adult vision exam (for eye refraction)	$0	Not covered

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

KPIC Gold PPO insurance plans

For effective dates 1/1/24–12/1/24

	Gold 80 PPO 350/25 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[23]**	**Non-Participating Provider Tier (out-of-network)[23]**
PLAN DEDUCTIBLE (Embedded)	Individual – $350[2] / Familiy – $700[2]	Individual – $1,000[2] / Family – $2,000[2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $7,800[24] / Family – $15,600[24]	Individual – $15,600 [2,24] / Family – $31,200[2,24]
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 services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0 [4,5,25,26]	40%[4,5,25, 26]
Well-child preventive care visits	$0 through age 23 months	40% through age 23 months
Fertility services	50% [27]	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 (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	 $15[9,28,29] $50[9,28,29] 25% per prescription up to $250 maximum[9,29]	 Not Covered Not Covered Not Covered
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	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 Outpatient (in the medical office)	$25	40% (after plan deductible)
Inpatient (in the hospital) - detoxification only	20% (after plan deductible)	40% (after plan deductible)
OTHER Virtual care	$0	$0
Acupuncture (physician referred)	$25 per visit	40% (after plan deductible
Certain durable medical equipment (DME) (supplemental and base)	20%[10,30]	40% (after plan deductible)[10,30]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[12]	20% (after plan deductible)[12]
Pediatric vision exam	$0	0% (after plan deductible)
Adult optical (eyewear)	Not Covered	Not Covered
Adult vision exam (for eye refraction)	$0	Not covered

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

KPIC Silver PPO insurance plans

For effective dates 1/1/24–12/1/24

	Silver 70 PPO 2500/55 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[23]**	**Non-Participating Provider Tier (out-of-network)[23]**
PLAN DEDUCTIBLE (Embedded)	Individual – $2,500[2] / Family – $5,000[2]	Individual – $5,000[2] / Family – $10,000[2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $8,750[2,24] / Family $17,500[2,24]	Individual– $17,500[2,24] / Family – $35,000[2,24]
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 services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0 [4,5,25,26]	40%[4,5,25, 26]
Well-child preventive care visits	$0 through age 23 months	40% through age 23 months
Fertility services	50%[27] (after plan deductible)	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)	35% (after plan deductible)	35% (after plan deductible)
Ambulance	35% (after plan deductible)	35% (after plan deductible)
PRESCRIPTIONS (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	$19[9,20,28,29] $85[9,20,28, 29] (after $300/$600 drug deductible) 30% per prescription up to $250 maximum (after $300/$600 drug deductible)[9,20,29]	Not Covered Not Covered Not Covered
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	35% (after plan deductible)	50% (after plan deductible)
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$55	40% (after plan deductible)
Inpatient (in the hospital)	35% (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	35% (after plan deductible)	50% (after plan deductible)
OTHER Virtual care	$0	$0
Chiropractic and acupuncture	$55 per visit	40% (after plan deductible)
Certain durable medical equipment (DME) (supplemental and base)	35%[10,30]	40% (after plan deductible)[10, 30]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[12]	20% (after plan deductible)[12]
Pediatric vision exam	$0	0% (after plan deductible)
Adult optical (eyewear)	Not Covered	Not Covered
Adult vision exam (for eye refraction)	$0	Not covered

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

KPIC Bronze PPO insurance plans

For effective dates 1/1/24–12/1/24

	Bronze 60 PPO 6300/60 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[23]**	**Non-Participating Provider Tier (out-of-network)[23]**
PLAN DEDUCTIBLE (Embedded)	Individual – $6,300[2] / Family – $12,600[2]	Individual – $12,600[2] / Family – $25,200[2]
OUT-OF-POCKET MAXIMUM (Embedded)	Individual – $9,100[2,24] / Family – $18,200[2,24]	Individual – $18,200[2,24] / Family – $36,400[2,24]
IN THE MEDICAL OFFICE Primary care visits	$60 (deductible applies after 1st 3 non-preventive visits)[22]	100% (up to out-of-pocket maximum)[32]
Urgent care visits	$60 (deductible applies after 1st 3 non-preventive visits)[22]	100% (up to out-of-pocket maximum)[32]
Specialty office visits	$95 (deductible applies after 1st 3 non-preventive visits)[22]	100% (up to out-of-pocket maximum)[32]
Preventive services (for example: screening exams, prenatal and postpartum visits, and immunizations)	$0[4, 5, 26, 26]	40%[4, 5, 25, 26]
Well-child preventive care visits	$0 through age 23 months	40% through age 23 months
Fertility services	40%[27] (after plan deductible)	Not Covered
Physical, occupational, and speech therapy	$60	100% (up to out-of-pocket maximum)[32]
Most laboratory tests	$40	100% (up to out-of-pocket maximum)[32]
Most X-rays and diagnostic testing	40% (after plan deductible)	100% (up to out-of-pocket maximum)[32]
Most MRI / CT / PET scans	40% (after plan deductible)	100% (up to out-of-pocket maximum)[32]
Outpatient surgery (per procedure)	40% (after plan deductible)	100% (up to out-of-pocket maximum)[32]
EMERGENCY SERVICES Emergency department visits (waived if admitted directly to hospital)	40% (after plan deductible)	40% (up to out-of-pocket maximum)[32]
Ambulance	40% (after plan deductible)	40% (up to out-of-pocket maximum)[32]
PRESCRIPTIONS (up to 30 day supply) Generic (Tier 1) Brand-name (Tier 2) Specialty drugs (Tier 4)	 $17 (after $500/$1,000 drug deductible)[9, 21, 28, 29] 40% per prescription up to $500 maximum (after $500/$1,000 drug deductible)[9, 21, 28, 29] 40% per prescription up to $500 maximum (after $500/$1,000 drug deductible)[9, 21, 29]	 Not Covered Not Covered Not Covered
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)[32]
MENTAL HEALTH SERVICES Outpatient (in the medical office)	$60	100% (up to out-of-pocket maximum)[32]
Inpatient (in the hospital)	40% (after plan deductible)	100% (up to out-of-pocket maximum)[32]
SUBSTANCE USE DISORDER SERVICES Outpatient (in the medical office)	$60	100% (up to out-of-pocket maximum)[32]
Inpatient (in the hospital) - detoxification only	40% (after plan deductible)	100% (up to out-of-pocket maximum)[32]
OTHER Virtual care	$0	$0
Acupuncture (physician referred)	$60 per visit (after plan deductible)	100% (up to out-of-pocket maximum)[32]
Certain durable medical equipment (DME) (supplemental and base)	40% (after plan deductible)[10,30]	100% (up to out-of-pocket maximum)[10, 30]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[12]	100% (up to out-of-pocket maximum)[12,32]
Pediatric vision exam	$0	0% (after plan deductible)
Adult optical (eyewear)	Not Covered	Not Covered
Adult vision exam (for eye refraction)	$0	Not covered

Refer to page 26 for the plan footnotes.

Refer to page 16 for the child dental benefits.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

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 or PPO 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 and 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.

DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

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.

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

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
SERVICES	**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 1/1/24–12/1/24

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	
SERVICES	**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 1/1/24–12/1/24

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®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

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	Member Pays
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
- Platinum 90 HMO 250/30 + Child Dental Alt
- Gold 80 HMO 0/35 + 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 2950/65 + 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*.

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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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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.

* This plan is also offered at Covered California for Small Business and CaliforniaChoice®.

† 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.

1. 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.
2. 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.
3. Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.
4. Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
5. Scheduled prenatal visits and postpartum visits.
6. Fertility benefits may be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.
7. Laboratory and diagnostic test, X-rays and MRI/CT/PET scans related to preventive services are no charge.
8. 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.
9. Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply.
10. Both base and supplemental DME are covered. Supplemental DME is limited to a combined maximum benefit of $2,000 per year for services. Refer to the Evidence of Coverage for information on what's included in your DME benefit.
11. After the 5 days, additional days for the same admission are covered at no charge.
12. Under age 19. One pair of eyeglasses from a limited selection.
13. Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months.
14. 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.
15. 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.
16. 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 $200 to $400 per employee. If the group covers dependents, the allowable funding range per family is $200 to $800.
17. For HSA-qualified HDHP HMO members, all scheduled, non-preventive telehealth visits (phone and video).
18. This plan has a drug deductible of $100 per individual and $200 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible 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.
19. This plan has a drug deductible of $250 per individual and $500 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible 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.
20. This plan has a drug deductible of $300 per individual and $600 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible 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.
21. This plan has a drug deductible of $500 per individual and $1,000 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible 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.
22. 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.
23. 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.
24. 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.
25. 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.
26. 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.
27. 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.
28. 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.
29. 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.
30. 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.
31. Limit doesn't apply to physical, occupational, and speech therapist visits in the home.
32. 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.

account.kp.org

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New group enrollment checklist

Once plans have been selected, refer to this enrollment checklist to keep track of everything for a smooth submission process.

Enrollment is as easy as 1-2-3. Visit **account.kp.org** to download the most current form to avoid processing delays, and type or print neatly using black ink, ensuring the completion of all fields on each form.

Brokers: Email group submission (items 1–3) to **kpsbubrokernewgroups@kp.org**. For assistance, call **800-789-4661**.

☐ 1. Employer Application

Completed and signed by authorized company signer.

☐ 2. Employee Enrollment

Completed and signed by each eligible employee/owner applying for coverage. Employees keep a copy for their records. Alternative form: Census form completed by the employer or company representative.

☐ 3. Initial Payment

The Electronic Transfer for Payment form is for the first month's payment with the option to set up recurring autopay (recommended). Complete the form, and do not include a blank or voided check. Processing of the initial payment is within 5–7 business days of contract activation. We do not accept credit card payments.

Employers must **complete and keep** the Declination for Coverage form listing all eligible and declining employees for their records.

Kaiser Permanente staff will perform internal checks to confirm the business structure prior to processing the group.
Note: Kaiser Permanente reserves the right to request additional documentation.

Additional enrollment tips

Submission deadlines

- The Employer Application must be submitted by the first business day of the effective month; supporting documents must be submitted no later than the fifth business day of the effective-date month.
- Groups submitted after the fifth business day of the effective-date month (complete or incomplete) will be automatically moved to the following effective date.
- A Late Enrollment Letter, signed by the broker and the group's authorized signer, must accompany all groups submitted after the first business day of the effective-date month.

Sole proprietorships/Partnerships

These groups don't qualify for enrollment without a W2 full-time employee on payroll. The W2 employee can enroll or waive group coverage.

Sole Proprietorships – An owner, spouse or domestic partner doesn't qualify as a W2 employee.

Partnerships – A partner, spouse or domestic partner doesn't qualify as a W2 employee.

Note: additional documents may be required to validate the employer/employee eligibility.

Groups with employees in Northern and Southern California

A group with 6 or more enrolling members outside of the group's home region will be set up with 2 contracts. Rates will be determined based on the headquarters of the group. Both contracts will be assigned unique group ID numbers. If an existing group grows to 13 or more subscribers in the non-home region, then separate north and south contracts are issued at renewal (rates are based on headquarter location for both Northern California and Southern California contracts).

Electronic signature

Electronic signature is the preferred method of collecting document signatures. Common platforms that are accepted include DocuSign, Adobe Sign, Ease, Employee Navigator, PRO Apply, and Verisign. These platforms indicate a document control number for each signature. In the event a platform doesn't have a document control number listed on the form, the confirmation page must be provided.

Contact us

For general underwriting and sales questions, contact us at **800-789-4661** or email kpsbubrokernewgroups@kp.org. You can find the latest Underwriting Guidelines here at account.kp.org.

Kaiser Permanente staff will perform internal checks to confirm the business structure prior to processing the group.
Note: Kaiser Permanente reserves the right to request additional documentation.

Small Business Guidelines

These guidelines apply to all employers offering Kaiser Permanente small business coverage. You can choose from any of our ACA-compliant metal plans, subject to eligibility requirements.

ELIGIBILITY

To be eligible for Kaiser Permanente's guaranteed issue and guaranteed renewable small business health plans, you must continuously meet certain requirements, as defined in the Affordable Care Act (ACA), the California Small Group Reform Act and as outlined below:

- You must offer health plan coverage to 100% of your eligible employees.
    - Your minimum contribution must be at least 50% of the employee premium for the lowest-priced Kaiser Permanente medical plan you offer.
- You must have at least one W-2 employee (not including the sole proprietor owner, partners, their spouse, or domestic partner) but no more than 100 full-time and full-time-equivalent employees for at least 50% of your business's working days for the previous calendar quarter or year.
  For Corporations and LLCs only: a corporate officer that is a W-2/common-law employee is considered an eligible employee. The officers can be spouses, domestic partners, or unrelated.
    - A full-time employee is a permanent employee actively engaged in the conduct of business on a full-time basis and must average 30 hours per week over the course of a month, be subject to withholding on a W-2 form, and have met your group's waiting period, if applicable.
    - Full-time-equivalent employees are a combination of employees, each of whom individually isn't a full-time employee (because they're not employed on average at least 30 hours per week), but who, in combination are counted as the equivalent of a full-time employee.

  Note: Kaiser Permanente allows employers the choice to offer coverage to employees working an average of at least 20 hours per week.
- You must ensure at least 50% of eligible employees are enrolled in a valid health plan. The following are valid health plan waivers if they are covered by:
    - another employer's health plan through a spouse, domestic partner, or parent
    - another health plan offered by this employer or another employer by which they are employed
    - Group coverage through COBRA or Cal-COBRA
    - Medicare, Medi-Cal, TRICARE (military or VA benefits) or an individual health plan.
- Kaiser Permanente reserves the right to determine what other types of health plan coverage qualify as valid coverage.
- If affiliated companies are eligible to file a combined tax return for the purposes of state taxation, they will be considered one employer to determine group size but may choose to apply for coverage separately.
- You must have workers' compensation insurance as required by law.
- You must qualify under our California live/work rules to be eligible for coverage.
    - Your physical business address must be located within the Kaiser Permanente service area or at least one enrolling eligible employee must live within our service area.
    - All Subscribers must live or work inside the Service Area applicable to their coverage when they enroll.

INELIGIBILITY

Your business is ineligible for small group coverage if it's wholly owned by you or you and your spouse, and you don't have at least one eligible employee other than you or your spouse.
For Corporations and LLCs only: a corporate officer that is a W-2/common-law employee is considered an eligible employee. The officers can be spouses, domestic partners, or unrelated. Contractors (1099), seasonal and temporary employees, private household help, and domestic help are ineligible for coverage.

METAL PLAN RATING

Benefit costs associated with health care delivery for all our small group customers affects our plan rates.

Metal plan rates are calculated using 2 factors — rating area and member age. Claims or utilization experience aren't used to determine member premium rates.

Rating area

- Businesses located in California: rates are based on the business's physical address (ZIP+4 and county).
- Businesses located outside of California are assigned to rating area 4.
- A post office box or other purchased mailing address can't be used as your business's physical address location.

Member age

- Each family member has a separate rate based on their age as of the effective date of the group contract. This rate will be used for the full contract year and updated yearly at renewal.
- A family will pay a premium per child up to 3 of the oldest children under age 21, each additional child after the third will be $0. Note: A premium will apply to every age from 21-26.
- Age bands are 0–14, 15, 16, 17, 18, 19, 20, every age from 21 to 63, and 64+.
- All plans include child dental for members under 19 years old, as of the group contract effective date. HMO plans apply the cost of child dental only to the 0–14, 15, 16, 17, 18 age bands. PPO plans* include the cost of child dental coverage in the overall rate.

*Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan.

Final rates are based on actual group enrollment. Rates are guaranteed for 12 months and are valid only from the effective date stated in the group contract.

GENERAL RULES AND REQUIREMENTS

- Your minimum contribution must be at least 50% of the employee premium for the lowest-priced Kaiser Permanente health plan you offer.
- The effective date of coverage for new employees and their eligible family dependents is always on the first of the month and that date must not go beyond the maximum 90-day waiting period, in accordance with the ACA guidelines.
- Kaiser Permanente Small Group permits our coverage to be written alongside another carrier's coverage ("sliced") in California only if that other coverage is a fully insured, age-rated, ACA-compliant small business metal or grandfathered (nonmetal) health plan. Exceptions: when a slice carrier has out of state employees, then composite rated, level-funded, or self-funded plans may be permitted.
- Kaiser Permanente doesn't write in slice position with CaliforniaChoice® or Covered California for Small Business (CCSB). Kaiser Permanente is offered as an option within these exchanges.

STATEWIDE EMPLOYERS

Kaiser Permanente operates as 2 regions and contracts with employers separately as Kaiser Foundation Health Plan, Inc., Northern California region and Kaiser Foundation Health Plan, Inc., Southern California region. Employers with employees enrolled in both regions, may be issued two separate contracts with unique group ID numbers and rates. The home region will be based on location of the headquarters or main location. Valid business documentation is required.

- New groups with 6 or more enrolled subscribers residing in the nonhome region, will be issued separate contracts for Northern California and Southern California.
- When existing groups increase to 13 or more enrolled subscribers residing in the nonhome region, a second contract for the nonhome region will be required at renewal.

MULTIPLE PLAN OPTIONS

The number of health plans you can offer to your employees is based on the number of enrolled Kaiser Permanente subscribers:

- Groups with 1 to 5 enrolled subscribers may offer up to 4 HMO Kaiser Permanente plans, plus 1 PPO plan for a maximum of 5 plans.
- Groups with 6 or more enrolled subscribers may offer 1 or more HMO Kaiser Permanente plans, plus 2 PPO plans.

PPO

- If you offer PPO plans, all eligible employees must be offered the PPO options and Kaiser Permanente must be the sole carrier.
- If you have out-of-state employees, the maximum subscribership can't exceed 49% of the overall group enrollment. For example: A group of 10 subscribers can't have more than 4 out-of-state employees on a PPO plan.

CHILD DENTAL

- All metal HMO and PPO plans cover the ACA-defined essential health benefits, including child dental coverage.
- HMO plan members are enrolled in a separate child dental benefit underwritten by Delta Dental of California.
- PPO plan members receive child dental PPO benefits as part of their medical coverage, not as a separate plan.
- Child dental services apply to all members under 19 years old. If a child turns 19 before the current contract renews, coverage is extended until the contract renewal date.

SUPPLEMENTAL FAMILY DENTAL PLANS (OPTIONAL)

- The optional supplemental family dental plans are available for an added cost.
- You may choose to offer one supplemental family dental plan to pair with your health plan and all subscribers and dependents will be enrolled.
- Our supplemental family dental plans cover adults and dependent children up to age 26, when dependent coverage is offered, at an extra cost. These plans do not substitute for the ACA required child dental coverage for members under 19 years old.
- The DeltaCare HMO family dental plan isn't offered with any PPO health plans.

CHIROPRACTIC AND ACUPUNCTURE

Combined coverage for chiropractic/acupuncture care is included in the following metal plans:

- Platinum 90 HMO 0/10 + Child Dental Alt
- Platinum 90 HMO 250/30 + Child Dental Alt
- Gold 80 HMO 0/35 + 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 2950/65 + Child Dental Alt
- Bronze 60 HMO 5400/60 + Child Dental Alt

INFERTILITY BENEFIT (OPTIONAL)

The optional infertility benefit is available for an added cost and only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier.

- Upon selection of this optional benefit, it will be added to all the HMO plans offered, as part of the original contract, or can be added or discontinued upon renewal.
- Infertility benefit is already included in all metal PPO plans.

DEDUCTIBLE CREDIT AND CARRYOVER

- We don't offer credit for expenses paid by members toward deductibles or out-of-pocket maximums in a medical or dental plan they had with another carrier prior to joining Kaiser Permanente.
- All Kaiser Permanente deductibles and out-of-pocket maximum accumulations reset to $0 at the start of the new calendar year. Accumulations are not carried over from the previous calendar year to the new calendar year.
- Deductible and out-of-pocket maximum accumulations will reset when your coverage transitions from Kaiser Permanente to CCSB or a private exchange, or from CCSB or a private exchange to Kaiser Permanente and/or reenrollment.

CAUSES FOR TERMINATION

Kaiser Permanente can terminate coverage under any of the following conditions if the employer:

- intentionally fails to enforce employee and dependent eligibility rules
- fails to pay required premiums after the grace period has lapsed
- fails to comply with underwriting requirements, including participation or contribution standards
- commits an act of fraud or intentional misrepresentation of material fact
- has no employees enrolled in a Kaiser Permanente small business plan
- moves outside Kaiser Permanente's approved California service areas and has no employees enrolled in a Kaiser Permanente small business plan who live in the service area.

Kaiser Permanente can terminate employee or dependent coverage if the individual directly or indirectly commits an act of fraud or intentional misrepresentation of material fact.

EXISTING ACCOUNTS

RE-ENROLLMENT AND REINSTATEMENT

Re-Enrollment — If your small group coverage has been terminated for more than 60 days, you may re-enroll as a new group provided you still qualify for small group coverage. You will then receive a new coverage effective date, group number and a new contract.

Reinstatement — If your small group coverage has been terminated for less than 60 days, you may request reinstatement of your prior contract to avoid a gap in coverage. Consideration of this request is conditional provided premiums are paid and you still qualify for small group coverage. Upon approval, your group will retain the same group number, renewal date and grandfather status, if applicable.

GRANDFATHER (NON-METAL) PLAN OPTIONS

Kaiser Permanente groups may continue to offer their existing grandfathered (nonmetal) plans if their plan(s) existed and covered at least one employee without any lapse or change in coverage status since the ACA was signed into law on March 23, 2010.

If a group currently offers a grandfathered (nonmetal) plan(s) and eliminates or replaces any of these plan(s) with a metal plan, then their grandfathered (nonmetal) plan(s) and status are lost for that plan(s). Additionally, a grandfathered (nonmetal) plan cannot be replaced by another grandfathered (nonmetal) plan. Some exceptions include a bona fide employment-based reason for the change (other than changing the terms or cost of coverage) or multiple plans remain and currently cover a significant portion of employees.

GRANDFATHER (NON-METAL) PLAN RATING

The rate calculation factors for grandfathered (nonmetal) plans are different from metal plans. Final rates are based on actual group enrollment. Rates are guaranteed for 12 months and are valid only from the effective date stated in the group contract.

Grandfathered (nonmetal) plan rating

Grandfathered (nonmetal) plan rates are calculated using 3 factors — rating area, age band, and risk adjustment factor (RAF).

Rating area

- If your business is located within our service area: rates are based on the business's physical address (ZIP+4).
- If your business is located outside our service area or out of state: rates are based on the ZIP+4 where the highest number of covered employees reside.
- A post office box or other purchased address can't be used as your business's physical address location.

Age band

- The subscriber's age as of the effective date of the group contract, plus the family size, is used to determine the rate. This rate is used for the full contract year and updated at renewal. Age bands are <30, 30–39, 40–49, 50–54, 55–59, 60–64, and 65+.
- Family size categories are:
    - Employee only
    - Employee and spouse
    - Employee and child or children
    - Employee, spouse, and child or children: If a family has more than one child under 26, the premium for each additional child after the first will be $0.

Risk adjustment factor (RAF)

- One RAF is applied to all grandfathered (nonmetal) plans and restricted to a 0.90 to 1.10 range. The RAF applied to your group at renewal won't increase by more than 10 percentage points from the RAF applied in the prior rating period.
- RAFs are calculated using a model that assigns risk scores to each enrolled member based on the member's age, gender, and the types of prescription drugs the member is taking.

Small Business
1094873396 June 2023

GRANDFATHER (NON-METAL) CHIROPRACTIC AND ACUPUNCTURE

The optional combined chiropractic/acupuncture coverage is available for grandfathered (nonmetal) plans for an added cost. This option is not available for the grandfathered HSA-qualified high deductible health plans (HDHP).

- If you offer chiropractic/acupuncture coverage, all subscribers and dependents must participate. except for out-of-state employees, who are only eligible for the chiropractic/acupuncture plan offered with the PPO plans.
- You can only add this coverage at renewal and can discontinue coverage anytime up to 4 months before your renewal date or at renewal.

RECERTIFICATION

Employer groups will periodically be required to recertify that their group continues to meet small business eligibility requirements as outlined in the eligibility section above.

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KAISER PERMANENTE®

California Small Group
EMPLOYER APPLICATION

Email your completed application to your Kaiser Permanente representative or your broker. We cannot process an incomplete application.

Requested effective date ____ / 01 / ____

1 ABOUT BUSINESS

Legal business name (as stated on your local business license, quarterly wage and tax report, corporate or partnership documents)	Doing business as (DBA)

Physical street address **(no P.O. boxes)**	City	State	ZIP	County

Phone ( ) –	Business website

Type of business ☐ Corporation ☐ Sole proprietorship ☐ Partnership ☐ Limited liability company (LLC) ☐ Other:

In business since (mm/dd/yyyy)	Federal tax ID (EIN) number	NAICS 6-digit code (visit **naics.com/search**)
/ /		

All employees must be covered by workers' compensation, unless not required to be covered by law. You're not eligible to apply for coverage if you don't have workers' compensation, unless you're exempt. I attest that the following information is correct.

☐ Yes, my company has workers' compensation. ☐ Pending

If *Yes* or *Pending*, name of carrier: _____ Policy # _____
(indicate *unknown* or *pending* as applicable)

☐ Exempt from providing workers' compensation for the following reason: _____

2 OTHER MEDICAL COVERAGE

Does your company or affiliated company(ies) have or ever had group coverage directly through Kaiser Permanente? If *Yes*, please provide the group number and company name.

☐ Yes ☐ No Group #: Company name:

Does your company currently have active group health coverage?

☐ Yes ☐ No Name of carrier: Renewal month:

Will you be offering another carrier's small group health plan, alongside Kaiser Permanente, to your employees?

☐ Yes ☐ No Name of carrier: **Number of employees enrolled:**

3A EMPLOYER ELIGIBILITY

In determining the number of employees or eligible employees, affiliated companies eligible to file a combined tax return for purposes of state taxation shall be considered 1 employer.

Is your company affiliated with another company and eligible to file a combined tax return? ☐ Yes ☐ No

If Yes, please provide below:

Company name _____ ☐ Affiliate ☐ Subsidiary

Address	City	State	ZIP

Federal tax ID (EIN) number	Phone ( ) –

Business name (please print): _____

3B EMPLOYEE COUNT

Please provide the total number of employees nationwide **(full-time and part-time).**

Total _____ **If the total number of employees noted is 100 or fewer, skip the following and go to section 3C.**

If your total number of employees noted above is more than 100, please provide the total number of **full-time and full-time-equivalent employees** on the line below. To qualify for small group coverage, your company must have at least 1 but no more than 100 full-time and full-time equivalent employees on at least 50% of the previous calendar quarter or previous calendar year. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to your legal counsel.

Total _____

3C ELIGIBLE AND ENROLLING EMPLOYEES

Please provide the total number of **eligible employees.** Total _____

Please provide the total number of **enrolling employees.** Total _____

Hours per week employees must work to be eligible for coverage: ☐ minimum 20 hours ☐ minimum 30 hours

Are you offering dependent coverage? ☐ Yes ☐ No

If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage. For more information about Employer Shared Responsibility, see section 4980H(C)(2) of the Internal Revenue Code.

3D DOMESTIC PARTNER COVERAGE

Are you offering non-state registered Domestic Partner Coverage? ☐ Yes ☐ No

4 CONTINUATION COVERAGE

Did your company employ 20 or more employees for at least 50% of the workdays of the preceding calendar year (January through December), making it subject to COBRA? ☐ Yes ☐ No

Are you submitting COBRA applications? ☐ Yes ☐ No

5A ERISA STATUS

Is your company subject to ERISA? ☐ Yes ☐ No If you don't select an answer, we'll record your status as Yes.

ERISA is a federal law that sets minimum standards for employee benefit plans established by private employers and employee organizations. Many group health plans are subject to ERISA, although government and church plans generally aren't. If you're unsure of your group health plan's ERISA status, we recommend that you consult with your financial or legal advisor before responding.

5B MEDICARE SECONDARY PAYOR STATUS

Are you subject to TEFRA? ☐ Yes ☐ No

If your company employed 20 or more full-time and/or part-time employees for each working date for 20 or more calendar weeks in the current calendar year or preceding calendar year, your group is subject to this federal law.

6 EMPLOYER PREMIUM CONTRIBUTION

Your contribution to coverage can be a percentage or a fixed dollar amount. **Your minimum contribution must be at least 50% of the "employee only" monthly premium for the lowest-priced Kaiser Permanente medical plan offered by you, the employer.**

Percentage of the premium is based on the following **(select 1 only):**
☐ Lowest plan offered ☐ All plans offered ☐ Specific plan offered: _____

Employer contribution (50%–100%): _____ % per employee _____ % per dependent **(optional)**
Employer contribution (fixed $): $ _____ per employee $ _____ per dependent **(optional)**

Business name (please print): _____

7A CONTRACT AND RENEWAL DELIVERY PREFERENCE

Kaiser Foundation Health Plan, Inc. (KFHP)/Kaiser Permanente Insurance Company (KPIC) contract(s) and renewal(s) are available online at **account.kp.org** unless you indicate below that you'd like your contract(s) and renewal(s) mailed to you.

Check box to receive printed versions by mail

☐ Contracts ☐ Renewals

7B CONTRACT SIGNER

This person is responsible for receiving and providing renewal information, and is authorized to make membership or contractual changes to your account. This address will become the group mailing address, if different from the business physical address.

First name	MI	Last name	Title

Mailing address	City	State	ZIP

Office phone ( ) –	Ext.	Cellphone ( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

7C BILLING CONTACT

The **billing contact** is the person within your company to whom billing statements are addressed. This person will have access to group information. Only 1 billing contact is allowed. **If you're using a Third-Party Administrator (TPA), including a broker acting as a TPA for billing administration, please skip the following and proceed to section 7D.**

☐ **Check here if same as contract signer.**

First name	MI	Last name

Mailing address	City	State	ZIP

Office phone ( ) –	Ext.	Cellphone ( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

Business name (please print): _____

7D THIRD-PARTY ADMINISTRATOR (TPA) CONTACT

The **TPA** is an external person, company, or broker that's contracted for the purpose of administering the group's billing and enrollment or solely administering your **Federal COBRA** benefits. **Note:** A TPA can't administer state Cal-COBRA. This person will have access to group information.

TPA company name

Will the TPA administer Federal COBRA? ☐ Yes ☐ No ☐ Check here if COBRA statement will be sent to group's billing address.

First name	MI	Last name

Mailing address	City	State	ZIP

Office phone	Ext.	Cellphone
( ) –		( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

7E INTERESTED PARTY CONTACT (OPTIONAL)

An **interested party** is an individual, within your organization, authorized to discuss and receive group specific information and make contract changes. This individual would be someone other than a broker. An authorized agent/broker is to complete section 10A.

First name	MI	Last name

☐ Check here if using the same address as the Contract Signer in section 7B.

Mailing address	City	State	ZIP

Office phone	Ext.	Cellphone
( ) –		( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

ADDITIONAL INTERESTED PARTY

First name	MI	Last name

☐ Check here if using the same address as the Contract Signer in section 7B.

Mailing address	City	State	ZIP

Office phone	Ext.	Cellphone
( ) –		( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

Business name (please print): _____

8A MEDICAL PLANS

Please select the plan(s) you'd like to offer. For more information on the plans listed below, contact your sales representative or agent/broker.
You're eligible to offer a choice of plans to your employees.

- Groups with 1 to 5 enrolled subscribers can offer a choice of up to 4 HMO Kaiser Permanente plans, plus 1 PPO plan for a maximum of 5 plans.
- Groups with 6 or more enrolled subscribers can offer a choice of 1 or more HMO Kaiser Permanente plans, plus 2 PPO plans.
- PPOs can only be offered when Kaiser Permanente is the sole carrier.

Platinum	☐ Platinum 90 HMO 0/10 + Child Dental Alt†	☐ Platinum 90 PPO 0/15 + Child Dental
	☐ Platinum 90 HMO 0/20 + Child Dental	
	☐ Platinum 90 HMO 250/30 + Child Dental Alt†	
Gold	☐ Gold 80 HMO 0/35 + Child Dental Alt†	☐ Gold 80 PPO 350/25 + Child Dental
	☐ Gold 80 HMO 250/35 + Child Dental	
	☐ Gold 80 HMO 1000/40 + Child Dental Alt†	
	☐ Gold 80 HDHP HMO 1750/15% + Child Dental Alt	
	☐ Gold 80 HRA HMO 2250/35 + Child Dental	
Silver	☐ Silver 70 HMO 1900/65 + Child Dental Alt†	☐ Silver 70 PPO 2500/55 + Child Dental
	☐ Silver 70 HMO 2300/65 + Child Dental Alt†	
	☐ Silver 70 HMO 2500/55 + Child Dental	
	☐ Silver 70 HMO 2950/65 + Child Dental Alt†	
	☐ Silver 70 HDHP HMO 2850/25% + Child Dental	
Bronze	☐ Bronze 60 HMO 5400/60 + Child Dental Alt†	☐ Bronze 60 PPO 6300/60 + Child Dental
	☐ Bronze 60 HMO 6300/60 + Child Dental	
	☐ Bronze 60 HDHP HMO 7050/0 + Child Dental	

Child Dental: We're required to include child dental benefits with your 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 plan underwritten by Delta Dental of California. PPO medical plan members receive child dental benefits as part of their medical coverage and not as a separate plan. Child dental services apply to all members under 19 years old.

†Chiropractic and acupuncture benefits are included with these plans.

Groups selecting the Gold 80 HRA HMO 2250/35 plan above must fund an HRA for each enrolled employee. The allowable funding range is $200 to $400 per employee. If the group covers dependents, the allowable funding range per family is $400 to $800.

HDHP plans are HSA-qualified. If you've selected an HDHP or HRA medical plan above, please indicate if you'd also like Kaiser Permanente to administer your HSA or HRA health payment account. **If you select *Yes*, a Kaiser Permanente representative will contact you to provide more information on your next steps, as additional documents and administrative fees apply.**

HSA administered through Kaiser Permanente? ☐ **Yes** ☐ **No** **HRA administered through Kaiser Permanente?** ☐ **Yes** ☐ **No**

8B INFERTILITY BENEFIT (OPTIONAL)

The optional infertility benefit is available only to groups with 20 or more eligible employees where Kaiser Permanente is the sole carrier. If you select this benefit, it will be added to all the HMO plans you offer and the cost will be included in the medical plan rate.

☐ Add infertility benefit

8C DENTAL PLANS

SUPPLEMENTAL FAMILY DENTAL PLANS

Our supplemental family dental plans cover the entire family, including adults and dependent children up to age 26. However, a supplemental family dental plan isn't a substitute for the child dental coverage required by Affordable Care Act (ACA) regulations for members under 19 years old. **Please select only 1 plan.** If you select this benefit, all enrolled subscribers will be enrolled in dental.

KPIC Fee-for-Service (Premier)	☐ Plan C	☐ Plan D	☐ Plan E	☐ Plan E with Ortho **(requires at least 10 subscribers)**	
KPIC PPO	☐ PPO AG 1500	☐ PPO AH 2000	☐ PPO D 1500	☐ PPO E 1000	☐ PPO E 1500
DeltaCare HMO	☐ 10A HMO	☐ 13B HMO			

Supplemental Family Dental plans are available only when purchased with a medical plan and all eligible subscribers and dependents must participate.
A medical PPO plan member living outside California isn't eligible for the DeltaCare HMO family dental plan.

Business name (please print): _____

9 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan, Inc. (KFHP), or Kaiser Permanente Insurance Company (KPIC) has completed its review and communicated to the business applicant or the applicant's broker that the application has been accepted and a group health plan contract/group policy will be issued.

The copay HMO plans, HSA-qualified high deductible health plans, deductible HMO plans, and the deductible HMO plans with HRA are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the Preferred Provider Organization (PPO) plans as well as the Premier and PPO dental plans. The chiropractic/acupuncture benefit is administered by American Specialty Health Plans of California, Inc.

10A AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE

To be completed by your Kaiser Permanente–appointed agent/broker after completion of this application. Your broker will have the same access to your account as an interested party with the exception that a broker can't sign this Employer Application. If you're a broker who hasn't registered as a firm or agent with Kaiser Permanente, please call Broker Sales at **800-789-4661.** If any information has changed, please call Broker Compensation at **800-440-2323.**

Notice to agent or broker: If you've assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies under current law.

You must select *Yes* or *No*:

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Yes ☐ No

Primary (authorized agent/broker)

Agent/broker name	% split
Firm name	Kaiser Permanente broker firm ID
Agent/broker signature **X**	Date

Secondary (only if adding another firm; doesn't apply to a second agent/broker at the same firm)

Agent/broker name	% split
Firm name	Kaiser Permanente broker firm ID

10B GENERAL AGENT ACCESS

Your agent/broker may work with a General Agent (GA) to service your organization, which is a different firm from your agent/broker. The same agent/broker access to your group specific information and change permission will be granted to a designated GA unless you choose not to authorize access.

Do not check the box below if you consent.

☐ Check this box **ONLY** if you **DO NOT** authorize a GA to access your group specific information, service your organization, change group information, or act on your behalf.

Business name (please print): _____

11 AGREEMENT AND SIGNATURE

Guaranteed Availability: Applications submitted between November 15th and December 15th with a January 1st effective date, may be subject to Guaranteed Availability, which means that your group cannot be denied for not meeting the minimum participation and contribution requirements during this timeframe.

Domestic Partner Coverage: Coverage for state-registered domestic partners is included in all small group plans. You may also offer coverage to those who are not registered with this state. Kaiser Permanente is not advising on whether or not the law requires coverage of these individuals. Please seek guidance from your counsel on dependent coverage obligations.

As a company principal/corporate officer, having authority to contract with KFHP and KPIC, I agree that:

- My group is automatically enrolled in on-line billing and prepaid monthly premiums will be posted to Kaiser Permanente's account by the due date on the Kaiser Permanente billing statement. For any questions, please call **800-731-4661.**
- My company will use employee enrollment application forms provided or approved by KFHP and KPIC for new employees.
- The eligibility data provided by my company to Kaiser Permanente will include coverage effective dates for my company's employees that correctly account for eligibility in compliance with the waiting period requirement in the Affordable Care Act and federal regulations, which require that waiting periods not exceed 90 days. My company acknowledges that the effective date of coverage for new employees and their eligible family dependents will be on the 1st of the month and won't exceed the waiting period established by my company.
- My company will abide by the contract provisions.
- All groups may be subject to a recertification process. Recertification is done to ensure that groups meet all Kaiser Permanente requirements and those set forth in the California Health and Safety Code and the Affordable Care Act.
- Upon request, my company will furnish to KFHP or KPIC all data necessary to verify group and employee eligibility including, but not limited to, data proving compliance with the underwriting requirements and terms of the group agreement.
- My company will maintain records of enrollment/waiver forms.

I have read, understood, and agreed to Kaiser Permanente's Small Business Guidelines, which may be included with my rate quote or, if not included, is available at **kp.org/smallbusinessguidelines/ca**.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law.

I attest that my company isn't participating in a large group trust and agree not to participate while enrolled under Kaiser Permanente small business coverage.

I understand that if I have an authorized agent/broker of record, then the agent/broker and their support staff currently on file with Kaiser Permanente will have access to my group-specific information. They're able to service my organization and to act or change group information on my behalf. Access to my account. kp.org group account will be granted to my agent/broker who may delegate authority to their support staff. This information may include, but isn't limited to, renewal notices, group agreements, rates, benefits, and protected health information (PHI).

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **kp.org/smallbusiness-sbc/ca**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

I understand that if KFHP or KPIC intends to rescind or terminate my coverage, I'll be sent a notice via regular certified mail at least 30 days prior to the effective date of the rescission or termination explaining the reasons for the intended rescission or termination and notifying me of my right to appeal that decision to the Department of Managed Health Care director or the Department of Insurance commissioner. I understand that after 24 months following the issuance of my KFHP health plan contract/KPIC health insurance policy, KFHP/KPIC shall not rescind my plan contract/policy for any reason, and shall not cancel my plan contract/policy, limit any of the provisions of my plan contract/policy, or raise premiums on my plan contract/policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition of obtaining coverage/health insurance coverage.

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. I understand that if I performed an act or practice constitutingfraud or made an intentional misrepresentation of material fact, any coverage approved by KFHP or KPIC may be canceled or the applicable premiums/rates may be adjusted.

CALIFORNIA FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to a health plan or an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance benefits, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the state's regulatory agency.

(continues on next page)

Business name (please print): _____

(continued from previous page)

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT[1]

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage.*

Authorized company signer (please print name)	Company title (please print)
Signature required for all Kaiser Permanente plans **X**	Date

[1]*Disputes arising from the following fully insured Kaiser Permanente Insurance Company coverages aren't subject to binding arbitration: 1) the Participating Provider tier and the Non-Participating Provider tier of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

KAISER PERMANENTE®

Small Business

ELECTRONIC TRANSFER FOR PAYMENT

INSTRUCTIONS

New Group: Return this form, along with your Employer Application, to your Kaiser Permanente sales representative and/or broker.

Existing Group: For future payments, email this form to **csc-sd-sba@kp.org** or fax to **855-355-5334.** To make a phone payment, call us at **800-731-4661** and choose the Payment Line option.

Note: Kaiser Permanente doesn't accept credit card payments for small group coverage.

COMPANY INFORMATION

Company name		Group ID (if assigned)
Phone ( ) –	Ext.	Email

AUTHORIZATION

I authorize Kaiser Permanente to withdraw the amount due, based on the final enrollment, from the account below:

Bank routing number **(9 digits)**	Bank account number

INITIAL PAY

One-time withdrawal for first month's payment based on Your Total Premium

Select one:

☐ **Save account information for future reference**

☐ **Do NOT** save account information for future reference

RECURRING PAYMENT

Check box only if you would like recurring payments.

☐ **Future autopay/recurring payment***

Withdraw statement balance 4 days prior to due date (other options are available at **account.kp.org** once your account is set-up).

*If selecting autopay, the first payment will be based on the first billing statement which can be as much as 2 months, due to billing cycles. If this payment is returned unpaid, I authorize Kaiser Permanente to resubmit the payment and charge this account an additional insufficient funds fee for the maximum amount allowed by the state as a result of a returned check.

READ AND SIGN

I affirm that I have authority to contract with Kaiser Foundation Health Plan, Inc. and Kaiser Permanente Insurance Company on behalf of the group.

Authorized company signer (please print name)	Company title (please print)
Signature **X**	Date

Confidentiality note: This information is intended only for the use of the individual or entity named above. If you're not the intended recipient, you're hereby notified that any disclosure, copying, distribution, or use of the information in the transmission is strictly prohibited. If you've received this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments.

KAISER PERMANENTE®

Small Business
EMPLOYEE ENROLLMENT

Use this form to enroll in Kaiser Permanente. (All fields with * are required.)

COMPANY & PLAN INFORMATION

Company name*	Group ID (if assigned)	Effective date* (can only start the first of the month) / 01 /
Plan selection*	**Subgroup ID** (if assigned)	Employee classification (if applicable)

Enrollment reason (Please check one) ☐ New group account ☐ Open enrollment ☐ Other:

If you have an **existing** account, please email completed form to **csc-sd-sba@kp.org** as a PDF attachment or fax to **855-355-5334.**

EMPLOYEE INFORMATION

Have you ever been a member of, or received care from, Kaiser Permanente in California? ☐ Yes ☐ No

Social Security number*	Former/Maiden name		
Last name*	First name*	MI	Preferred language (optional)
Home address*			Apt. #
City*	State*	ZIP*	County
Mailing address (if different from home)			Apt. #
City	State	ZIP	County
Date of birth (mm/dd/yyyy)* / /	Gender* ☐ M ☐ F ☐ Undeclared	Day phone ( ) –	Evening phone ( ) –

If you decline coverage for yourself or an eligible dependent, you can only enroll during an annual open enrollment period established by your employer, or during a special enrollment period if you've experienced a qualifying event. You must request coverage within 60 days of a qualifying event. Special enrollment qualifying events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court order that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that's serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that's been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual didn't enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

*(All fields with * are required.)*

KAISER PERMANENTE®

Small Business
EMPLOYEE ENROLLMENT

FAMILY INFORMATION (Please list only those family members to be enrolled.)

Check one ☐ Spouse ☐ Domestic partner	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)*			
Former name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			
☐ Dependent*	Date of birth (mm/dd/yyyy)*	Gender* ☐ M ☐ F ☐ Undeclared	Social Security number
Name (Last, First, MI)			

If any dependent listed above lives at another address, complete the following:

Name (Last, First, MI)	Address
Name (Last, First, MI)	Address

READ AND SIGN

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT†

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that can't be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Employee name (please print)*

Employee signature* X	Date

(All fields with * are required.)

†Disputes arising from fully insured Kaiser Permanente Insurance Company (KPIC) coverage aren't subject to binding arbitration: 1) Preferred Provider Organization (PPO) plans and 2) KPIC Dental plans.

Email completed form to **csc-sd-sba@kp.org** or fax to **855-355-5334.**

KAISER PERMANENTE®

Small Business

DECLINATION OF COVERAGE

(Employer Attestation)

IMPORTANT INFORMATION

Please use this form to list your employees who have declined coverage. If employees have filled out the Waiver of Coverage form, please transfer their information onto the list below and submit to your Kaiser representative. Keep a copy of this form for your records. **To terminate a subscriber, please use the Subscriber Termination, Transfer, and Reinstatement form.**

1 COMPANY INFORMATION

Company name	Group ID (if assigned)

2 REASONS FOR DECLINING

Kaiser Permanente group health coverage has been offered to the eligible employees listed below. These employees have voluntarily chosen not to enroll in a Kaiser Permanente plan at this time for one of the following reasons:

1. Covered by another employer's health plan through a spouse, domestic partner, or parent
2. Covered by another health plan offered by this employer
3. Covered by another employer they work for
4. Group coverage through COBRA or Cal-COBRA
5. Covered by Medicare, Medi-Cal, or TRICARE (military or VA benefits)
6. Covered by an individual health plan
7. Not interested in enrolling at this time

Avoid processing delays by assuring the reason code is completed below. **Use reason codes 1–7 listed above.**

First name	Last name	**Reason code (required)**

To list additional employees, please make copies of this form, as needed. All copies of this form must be signed.

Groups enrolling during Guaranteed Availability (November 15–December 15) are exempt from completing the required reason code above and meeting participation and contribution requirements.

Please note: Groups enrolling under Guaranteed Availability may be flagged to undergo recertification and will be required to meet all underwriting criteria, including participation and contribution requirements, at that time.

3 READ AND SIGN

I affirm that I have authority to contract with Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company on behalf of the group. I understand that the next opportunity to enroll will be during the annual open enrollment period or after a qualifying event.

Authorized company signer (please print name)	Company title (please print)
Signature X	Date

KAISER PERMANENTE®

PRIMARY ADMINISTRATOR ONLINE ACCESS REQUEST

For more information: California **800-893-2971, option 3**
Outside California **866-575-3562**

IMPORTANT INFORMATION

To ensure that you choose the correct option below, refer to the following descriptions. If you'd like to add a secondary administrator, **don't use this form** – reach out to the primary administrator to grant you access.

New Primary Administrator: A group requesting access for the first time. Email completed form to CSC-SD-CAS-Web-Support@kp.org. Note: this form is for active accounts only; submit this form when a group number has been assigned.

Change Primary Administrator: A group that already has access to *Online Account Services* and would like to replace their current primary administrator.

Note: This form is for online access only. To avoid processing delays, this form must be completed in its entirety.

☐ New Primary Administrator ☐ Change Primary Administrator

1 COMPANY BUSINESS INFORMATION

Company name*		Group ID
Company name	State/Region	Group ID
Company name	State/Region	Group ID
Company name	State/Region	Group ID

*If you have multiple companies (in CA or out of state), or multiple group IDs, include all above.

2 COMPANY PRIMARY ADMINISTRATOR INFORMATION

The primary administrator ID is non-transferable. Kaiser Permanente must be notified of any changes to the primary administrator.

First name	MI	Last name	Company role
Street address	City	State	ZIP
Phone ( ) –	Ext.	Email	

If you're an authorized third-party for the group, indicate company name.

3 READ AND SIGN

I affirm I have the authority to contract on behalf of the employer for health care coverage. Kaiser Foundation Health Plan, Inc (KFHP) may provide Personal Health Information (PHI) only to those third parties who are identified by a group as its business associates. KFHP must receive written assurance from the group that a business associate agreement exists between the group and the third party and that the business associate agreement permits the business associate to receive requested PHI information from KFHP. By signing below, the group agrees that a business associate agreement exists, KFHP may disclose to the third party PHI as necessary to provide services for or on behalf of the group and the group will immediately inform KFHP when the business associate has been terminated.

Signature (required)

X

Printed name (required)	Phone ( ) –	Date

Email: CSC-SD-CAS-Web-Support@kp.org
Fax: 855-355-5334

Lighten your workload with preenrollment support

Our licensed specialists can help lighten your workload by directly answering your employees' questions about Kaiser Permanente care and coverage.

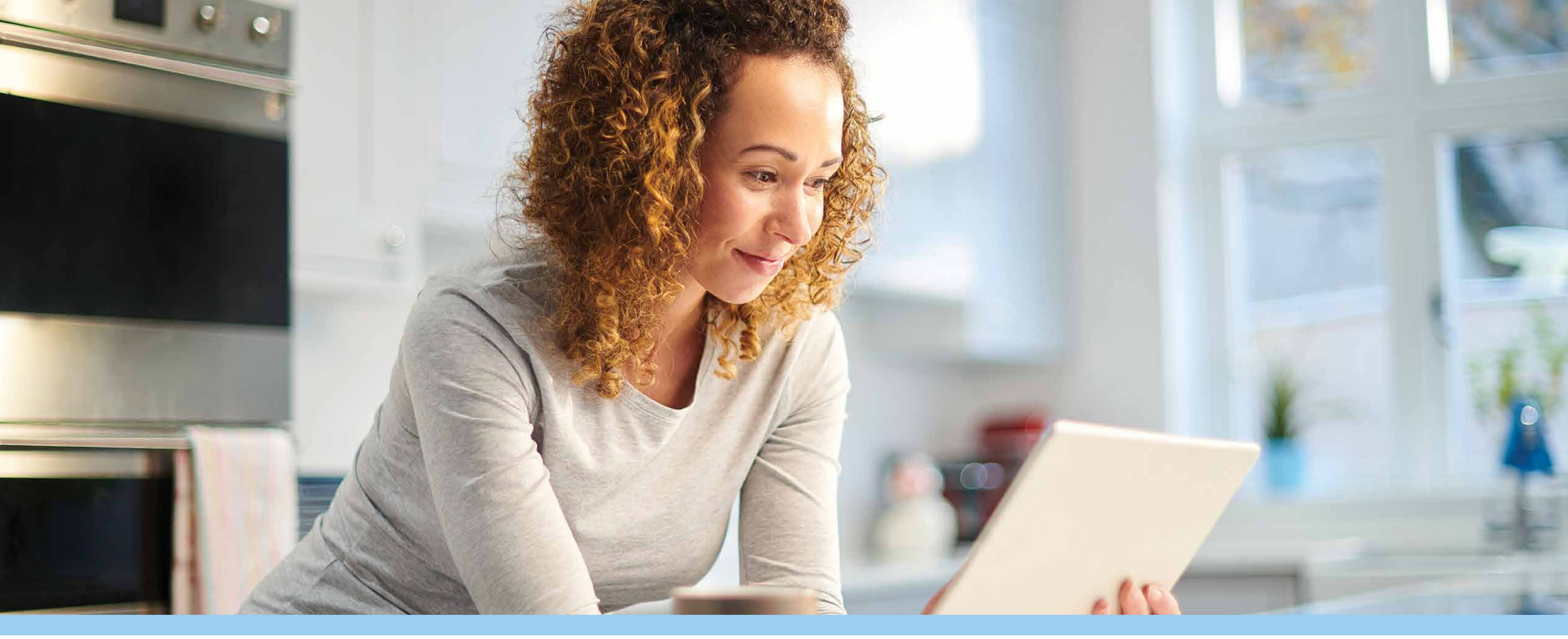
Our licensed specialists can answer questions about:

- Cost and coverage details
- Benefits of our integrated care and coverage model
- Access to specialty care and telehealth services
- Prescription drugs covered by different plans
- Wellness classes, podcasts, self-care resources, and more

We make it easy for your employees to connect:

- Dedicated phone line open Monday through Friday, 7 a.m. to 6 p.m. Pacific time
- Live agent call or text options
- English and Spanish support
- Employee-ready communication materials

Share the **Questions about Kaiser Permanente?** flyer with your new employees. For more information about Kaiser Permanente's preenrollment services, contact your broker or Kaiser Permanente representative.



Questions about Kaiser Permanente?

Talk to a licensed specialist. We're here to help.

Choosing a health plan is a big decision, but you don't have to make it alone. Our licensed specialists are here to help you make an informed decision and choose a plan that's right for you.

Ask about the essentials and additional services including:

- Where you can get care
- Video visits[1] and other convenient ways to get care remotely
- How our integrated care model benefits you
- Specialty care services
- Convenient pharmacy options
- Wellness classes, podcasts, self-care resources, and more[2]

Scan the QR code to text a licensed specialist.

Get in touch

Call us at **1-855-925-2991,** Monday through Friday, 7 a.m. to 6 p.m. Pacific time.

1. When appropriate and available. **2.** The services described above are not covered under your health plan benefits and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may require a fee and may be discontinued at any time without notice. • Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 1300 SW 27th St., Renton, WA 98057

Learn more at **k-p.li/JoinKP**

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