SMALL GROUP

KAISER PERMANENTE

KP Plans - BRONZE

KP/6250/20/60/S8

FEATURES	
DEDUCTIBLE (Individual/Family)	$6,250 / $12,500
OUT-OF-POCKET MAXIMUM (Individual/Family)	$8,500 / $17,000
MAXIMUM BENEFIT WHILE COVERED [1]	Unlimited
COINSURANCE (after deductible)	20%
OFFICE SERVICES	
Telehealth Visits	$0
Primary Care	$60 after deductible (deductible waived for first 3 visits)
Specialty Care	$80 after deductible
Mental Health/Chemical Dependency	$60 after deductible (deductible waived for first 3 visits)
Chiropractic Care (spinal manipulation only; 20 visits per calendar year)	20%
Vision Exam	$60
Laboratory Services	20%
Radiology Services	20%
High Tech Radiology Services (MRI, CT, PET, others)	20%
Preventive Services	$0
EMERGENCY SERVICES	
Emergency Room (per visit; copay waived if admitted)	20%
Ambulance (per trip)	20%
Urgent Care (per visit)	$120 after deductible (deductible waived for first 3 visits)
OUTPATIENT SERVICES	
Laboratory Services	20%
Radiology Services	20%
High Tech Radiology Services (MRI, CT, PET, others)	20%
Outpatient Hospital or Surgical Facility	20%
Physician and Other Professional Fees	20%
INPATIENT SERVICES	
Hospital (facility)	20%
Physician and Other Professional Fees	20%
Mental Health/Chemical Dependency	20%
PHARMACY SERVICES [2]	
Prescription Drug Deductible	Medical deductible applies (except Tier 1 and Tier 2 Generics)
Tier 1 Generic Drugs	$5 KP / $15 Affiliated
Tier 2 Generic Drugs	$20 KP / $30 Affiliated
Tier 3 Preferred Brand Drugs	$60 KP / $80 Affiliated
Tier 4 Non-Preferred Drugs	$100 KP / $130 Affiliated
Tier 5 Specialty Drugs	20% KP / 30% Affiliated
Mail Order [3]	$10 / $40 / $120 / $200 / 20%

KP and HDHP plans are also available on the SHOP *(with the exception of Platinum Plans KP/0/0/20/S8 and KP/500/20/20/S8)*

1 Some benefits may have limitations.

2 Refills must be obtained at a Kaiser Permanente Pharmacy or through Mail Order.

3 Available 90 day supply through Kaiser Permanente Pharmacy.

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SMALL GROUP

KAISER PERMANENTE

KP Plans - BRONZE HDHP/6850/0/S8

FEATURES	
DEDUCTIBLE (Individual/Family)	$6,850 / $13,700
OUT-OF-POCKET MAXIMUM (Individual/Family)	$6,850 / $13,700
MAXIMUM BENEFIT WHILE COVERED [1]	Unlimited
COINSURANCE (after deductible)	0%
OFFICE SERVICES	
Telehealth Visits	0%
Primary Care	0%
Specialty Care	0%
Mental Health/Chemical Dependency	0%
Chiropractic Care (spinal manipulation only; 20 visits per calendar year)	0%
Vision Exam	0%
Laboratory Services	0%
Radiology Services	0%
High Tech Radiology Services (MRI, CT, PET, others)	0%
Preventive Services	$0
EMERGENCY SERVICES	
Emergency Room (per visit; copay waived if admitted)	0%
Ambulance (per trip)	0%
Urgent Care (per visit)	0%
OUTPATIENT SERVICES	
Laboratory Services	0%
Radiology Services	0%
High Tech Radiology Services (MRI, CT, PET, others)	0%
Outpatient Hospital or Surgical Facility	0%
Physician and Other Professional Fees	0%
INPATIENT SERVICES	
Hospital (facility)	0%
Physician and Other Professional Fees	0%
Mental Health/Chemical Dependency	0%
PHARMACY SERVICES [2]	
Prescription Drug Deductible	Medical deductible applies (except Tier 1 Generics)
Tier 1 Generic Drugs	$5 KP / $15 Affiliated
Tier 2 Generic Drugs	0% KP / 0% Affiliated
Tier 3 Preferred Brand Drugs	0% KP / 0% Affiliated
Tier 4 Non-Preferred Drugs	0% KP / 0% Affiliated
Tier 5 Specialty Drugs	0% KP / 0% Affiliated
Mail Order [3]	$10 / 0% / 0% / 0% / 0%

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SMALL GROUP

KAISER PERMANENTE

KP Plans - GOLD

KP/0/0/40/S8

FEATURES	
DEDUCTIBLE (Individual/Family)	N/A
OUT-OF-POCKET MAXIMUM (Individual/Family)	$8,150 / $16,300
MAXIMUM BENEFIT WHILE COVERED [1]	Unlimited
COINSURANCE (after deductible)	0%
OFFICE SERVICES	
Telehealth Visits	$0
Primary Care	$40
Specialty Care	$70
Mental Health/Chemical Dependency	$40
Chiropractic Care (spinal manipulation only; 20 visits per calendar year)	$70
Vision Exam	$40
Laboratory Services	$0
Radiology Services	$50
High Tech Radiology Services (MRI, CT, PET, others)	$550
Preventive Services	$0
EMERGENCY SERVICES	
Emergency Room (per visit; copay waived if admitted)	$650
Ambulance (per trip)	$350
Urgent Care (per visit)	$80
OUTPATIENT SERVICES	
Laboratory Services	$0
Radiology Services	$50
High Tech Radiology Services (MRI, CT, PET, others)	$550
Outpatient Hospital or Surgical Facility	$700
Physician and Other Professional Fees	$0
INPATIENT SERVICES	
Hospital (facility)	$950 copay per day for first 3 days
Physician and Other Professional Fees	$0
Mental Health/Chemical Dependency	$950 copay per day for first 3 days
PHARMACY SERVICES [2]	
Prescription Drug Deductible	N/A
Tier 1 Generic Drugs	$5 KP / $15 Affiliated
Tier 2 Generic Drugs	$10 KP / $20 Affiliated
Tier 3 Preferred Brand Drugs	$60 KP / $80 Affiliated
Tier 4 Non-Preferred Drugs	$100 KP / $130 Affiliated
Tier 5 Specialty Drugs	35% KP / 35% Affiliated
Mail Order [3]	$10 / $20 / $120 / $200 / 35%

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1 Some benefits may have limitations.

2 Refills must be obtained at a Kaiser Permanente Pharmacy or through Mail Order.

3 Available 90 day supply through Kaiser Permanente Pharmacy.

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SMALL GROUP

KAISER PERMANENTE

KP Plans - GOLD

KP/3500/0/30/S8

FEATURES	
DEDUCTIBLE (Individual/Family)	$3,500 / $7,000
OUT-OF-POCKET MAXIMUM (Individual/Family)	$8,150 / $16,300
MAXIMUM BENEFIT WHILE COVERED [1]	Unlimited
COINSURANCE (after deductible)	0%
OFFICE SERVICES	
Telehealth Visits	$0
Primary Care	$30
Specialty Care	$60
Mental Health/Chemical Dependency	$30
Chiropractic Care (spinal manipulation only; 20 visits per calendar year)	$60
Vision Exam	$30
Laboratory Services	$0
Radiology Services	$60
High Tech Radiology Services (MRI, CT, PET, others)	$500
Preventive Services	$0
EMERGENCY SERVICES	
Emergency Room (per visit; copay waived if admitted)	$650
Ambulance (per trip)	$350
Urgent Care (per visit)	$60
OUTPATIENT SERVICES	
Laboratory Services	$0
Radiology Services	$60
High Tech Radiology Services (MRI, CT, PET, others)	$500
Outpatient Hospital or Surgical Facility	0%
Physician and Other Professional Fees	0%
INPATIENT SERVICES	
Hospital (facility)	0%
Physician and Other Professional Fees	0%
Mental Health/Chemical Dependency	0%
PHARMACY SERVICES [2]	
Prescription Drug Deductible	N/A
Tier 1 Generic Drugs	$5 KP / $15 Affiliated
Tier 2 Generic Drugs	$20 KP / $30 Affiliated
Tier 3 Preferred Brand Drugs	$50 KP / $70 Affiliated
Tier 4 Non-Preferred Drugs	$80 KP / $110 Affiliated
Tier 5 Specialty Drugs	25% KP / 25% Affiliated
Mail Order [3]	$10 / $40 / $100 / $160 / 25%

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2 Refills must be obtained at a Kaiser Permanente Pharmacy or through Mail Order.

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SMALL GROUP

KAISER PERMANENTE

KP Plans - GOLD

KP/4500/0/30/S8

FEATURES	
DEDUCTIBLE (Individual/Family)	$4,500 / $9,000
OUT-OF-POCKET MAXIMUM (Individual/Family)	$8,150 / $16,300
MAXIMUM BENEFIT WHILE COVERED [1]	Unlimited
COINSURANCE (after deductible)	0%
OFFICE SERVICES	
Telehealth Visits	$0
Primary Care	$30
Specialty Care	$60
Mental Health/Chemical Dependency	$30
Chiropractic Care (spinal manipulation only; 20 visits per calendar year)	$60
Vision Exam	$30
Laboratory Services	$0
Radiology Services	$60
High Tech Radiology Services (MRI, CT, PET, others)	$500
Preventive Services	$0
EMERGENCY SERVICES	
Emergency Room (per visit; copay waived if admitted)	$650
Ambulance (per trip)	$350
Urgent Care (per visit)	$60
OUTPATIENT SERVICES	
Laboratory Services	$0
Radiology Services	$60
High Tech Radiology Services (MRI, CT, PET, others)	$500
Outpatient Hospital or Surgical Facility	0%
Physician and Other Professional Fees	0%
INPATIENT SERVICES	
Hospital (facility)	0%
Physician and Other Professional Fees	0%
Mental Health/Chemical Dependency	0%
PHARMACY SERVICES [2]	
Prescription Drug Deductible	N/A
Tier 1 Generic Drugs	$5 KP / $15 Affiliated
Tier 2 Generic Drugs	$20 KP / $30 Affiliated
Tier 3 Preferred Brand Drugs	$50 KP / $70 Affiliated
Tier 4 Non-Preferred Drugs	$80 KP / $110 Affiliated
Tier 5 Specialty Drugs	25% KP / 25% Affiliated
Mail Order [3]	$10 / $40 / $100 / $160 / 25%

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SMALL GROUP

KAISER PERMANENTE

KP Plans - SILVER

KP/5500/0/50/S8

FEATURES	
DEDUCTIBLE (Individual/Family)	$5,500 / $11,000
OUT-OF-POCKET MAXIMUM (Individual/Family)	$8,500 / $17,000
MAXIMUM BENEFIT WHILE COVERED [1]	Unlimited
COINSURANCE (after deductible)	0%
OFFICE SERVICES	
Telehealth Visits	$0
Primary Care	$50
Specialty Care	$80
Mental Health/Chemical Dependency	$50
Chiropractic Care (spinal manipulation only; 20 visits per calendar year)	$80
Vision Exam	$50
Laboratory Services	$0
Radiology Services	$50
High Tech Radiology Services (MRI, CT, PET, others)	$450 after deductible
Preventive Services	$0
EMERGENCY SERVICES	
Emergency Room (per visit; copay waived if admitted)	$600 after deductible
Ambulance (per trip)	$350 after deductible
Urgent Care (per visit)	$100
OUTPATIENT SERVICES	
Laboratory Services	$0
Radiology Services	$50
High Tech Radiology Services (MRI, CT, PET, others)	$450 after deductible
Outpatient Hospital or Surgical Facility	$200 after deductible
Physician and Other Professional Fees	0%
INPATIENT SERVICES	
Hospital (facility)	$500 after deductible
Physician and Other Professional Fees	0%
Mental Health/Chemical Dependency	$500 after deductible
PHARMACY SERVICES [2]	
Prescription Drug Deductible	N/A
Tier 1 Generic Drugs	$5 KP / $15 Affiliated
Tier 2 Generic Drugs	$20 KP / $30 Affiliated
Tier 3 Preferred Brand Drugs	$50 KP / $70 Affiliated
Tier 4 Non-Preferred Drugs	$80 KP / $110 Affiliated
Tier 5 Specialty Drugs	30% KP/ 35% Affiliated
Mail Order [3]	$10 / $40 / $100 / $160 / 30%

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SMALL GROUP

KAISER PERMANENTE

KP Plans - SILVER KP/5500/0/50/S8

FEATURES	
DEDUCTIBLE (Individual/Family)	$5,500 / $11,000
OUT-OF-POCKET MAXIMUM (Individual/Family)	$8,500 / $17,000
MAXIMUM BENEFIT WHILE COVERED [1]	Unlimited
COINSURANCE (after deductible)	0%
OFFICE SERVICES	
Telehealth Visits	$0
Primary Care	$50
Specialty Care	$80
Mental Health/Chemical Dependency	$50
Chiropractic Care (spinal manipulation only; 20 visits per calendar year)	$80
Vision Exam	$50
Laboratory Services	$0
Radiology Services	$50
High Tech Radiology Services (MRI, CT, PET, others)	$450 after deductible
Preventive Services	$0
EMERGENCY SERVICES	
Emergency Room (per visit; copay waived if admitted)	$600 after deductible
Ambulance (per trip)	$350 after deductible
Urgent Care (per visit)	$100
OUTPATIENT SERVICES	
Laboratory Services	$0
Radiology Services	$50
High Tech Radiology Services (MRI, CT, PET, others)	$450 after deductible
Outpatient Hospital or Surgical Facility	$200 after deductible
Physician and Other Professional Fees	0%
INPATIENT SERVICES	
Hospital (facility)	$500 after deductible
Physician and Other Professional Fees	0%
Mental Health/Chemical Dependency	$500 after deductible
PHARMACY SERVICES [2]	
Prescription Drug Deductible	N/A
Tier 1 Generic Drugs	$5 KP / $15 Affiliated
Tier 2 Generic Drugs	$20 KP / $30 Affiliated
Tier 3 Preferred Brand Drugs	$50 KP / $70 Affiliated
Tier 4 Non-Preferred Drugs	$80 KP / $110 Affiliated
Tier 5 Specialty Drugs	30% KP/ 35% Affiliated
Mail Order [3]	$10 / $40 / $100 / $160 / 30%

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