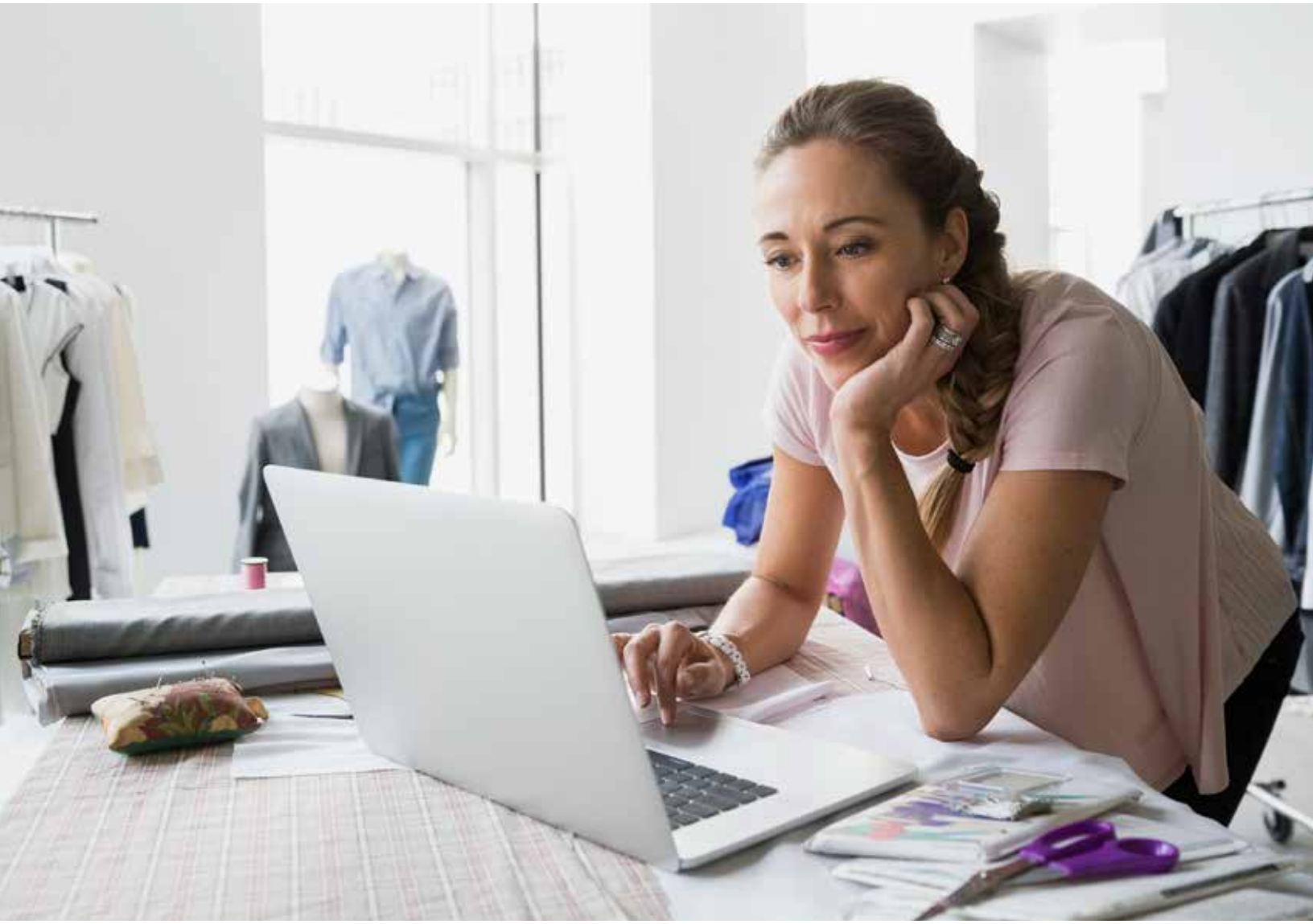

Plan Highlights
Metal Plans

For effective dates July 1 to December 1, 2019

KAISER PERMANENTE®

Notes for all plans

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

What's inside

Your medical plan options

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

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

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

- Platinum 90 HMO 0/10 + Child Dental Alt[1]
- Platinum 90 HMO 0/15 + Child Dental
- Gold 80 HMO 0/30 + Child Dental

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

- Gold 80 HMO 500/30 + Child Dental Alt[1]
- Silver 70 HMO 1000/55 + Child Dental Alt[1]
- Silver 70 HMO 1800/55 + Child Dental Alt[1]
- Silver 70 HMO 2000/45 + Child Dental
- Bronze 60 HMO 6300/75 + Child Dental

HSA-qualified High Deductible Health Plans (HDHP) – These deductible HMO plans can be paired with a health savings account (HSA) administered through Kaiser Permanente, giving your employees the option to open an HSA. They can contribute pretax or tax-deductible dollars[2] to the HSA and use that money to pay for qualified medical expenses. For a complete list of qualified medical expenses, see IRS Publication 502, *Medical and Dental Expenses*, at **irs.gov/publications**. (Refer to page 4 for more details.)

- Silver 70 HDHP HMO 2500/20% + Child Dental
- Bronze 60 HDHP HMO 6000/40% + Child Dental

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

- Gold 80 HRA HMO 2250/35 + Child Dental

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

- Platinum 90 PPO 0/15 + Child Dental
- Gold 80 PPO 0/30 + Child Dental
- Silver 70 PPO 2000/45 + Child Dental
- Bronze 60 PPO 6300/75 + Child Dental

[1]The abbreviation "ALT" in the plan names designates Kaiser Permanente developed "alternate" plans that supplement those available through Covered California for Small Business and California*Choice*®.

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

Health Payment Accounts

HSA/HRA administration through Kaiser Permanente

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

HSAs

- An HSA is an employee-owned account that can be used to pay qualified medical expenses.
- Your employees get triple tax savings with pre-tax contributions through payroll, tax-free interest earnings, and tax-free withdrawals to pay for qualified expenses.[1]
- A monthly administrative fee of $3.25, per employee account, can be paid by you or your employees.
- Available to eligible employees enrolled in the Bronze 60 HDHP HMO 6000/40% + Child Dental or the Silver 70 HDHP HMO 2500/20% + Child Dental benefit plans.[2]

HRAs[3]

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

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

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

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

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

[3]Groups selecting the Gold HRA HMO 2250/35 Deductible HMO with HRA plan must establish and fund an HRA for each enrolled employee. The allowable funding range is $200 to $500 per employee. If the group covers dependents, the allowable funding range per family is $400 to $1,000.

Understanding health plans

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

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

	Bronze 60 ① HMO 6300/75* + Child Dental
FEATURES	Deductible HMO Plan
❷ **PLAN DEDUCTIBLE** Embedded	Individual – $6,300[10,20] ❸ Family – $12,600[10,20]
❹ **OUT-OF-POCKET MAXIMUM** Embedded	Individual – $7,550[1,10] ❸ Family – $15,100[1,10]
IN THE MEDICAL OFFICE Primary care visits	$75 (after plan deductible)[2]
Urgent care visits	$75 (after plan deductible)[2]
Specialty office visits	$105 (after plan deductible)[2]
Preventive exams, vaccines (immunizations)	$0[12] ❺
Prenatal care	$0[3]
Postpartum care	$0[3]
Well-child preventive care visits	$0[23]
Allergy injections	$5 (after plan deductible)
Infertility services	Not covered[17]
Physical, occupational, and speech therapy	$75 ❻
Most laboratory tests	$40
Most X-rays and diagnostic testing	100% (up to out-of-pocket maximum)[20]
Most MRI/CT/PET scans	100% (up to out-of-pocket maximum)[20]
Outpatient surgery (per procedure)	100% (up to out-of-pocket maximum)[20]
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	100% (up to out-of-pocket maximum)[20]
Ambulance	100% (up to out-of-pocket maximum)[20]
PRESCRIPTIONS Generic drugs	100% per prescription up to $500 maximum (after $500 drug deductible) (up to a 30-day supply)[24]
Brand-name drugs	100% per prescription up to $500 maximum (after $500 drug deductible) (up to a 30-day supply)[24]
Specialty drugs	100% per prescription up to $500 maximum (after $500 drug deductible) (up to a 30-day supply)[24]
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	100% (up to out-of-pocket maximum)[20] ❼
Skilled nursing facility care (up to 100 days per benefit period)	100% (up to out-of-pocket maximum)[20]
MENTAL HEALTH SERVICES In the medical office	$75 (after plan deductible)[2]
In the hospital	100% (up to out-of-pocket maximum)[20]
CHEMICAL DEPENDENCY SERVICES In the medical office	$75 (after plan deductible)[2]
In the hospital (detoxification only)	100% (up to out-of-pocket maximum)[20]
OTHER Televisits	$0
Chiropractic and acupuncture	$75 per visit (after plan deductible)[2] for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	100% (up to out-of-pocket maximum)[6,20] (base only)
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[8]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	100% (up to out-of-pocket maximum)[20]
Hospice care	$0

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

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

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

3. Embedded accumulation
Each individual family member will begin paying copays or coinsurance after meeting his or her individual deductible, or when the family deductible is satisfied, whichever comes first. Also, individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met, whichever comes first. Not all services are subject to the deductible and/or out-of-pocket maximum.

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

5. Preventive care at no charge
Most preventive services are covered at no charge and aren't subject to the deductible.

6. Copay
The set amount employees will pay for certain services.

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

Kaiser Permanente Platinum HMO plans

Plan Highlights

For effective dates 7/1/19–12/1/19
*Also available in Covered California and California*Choice*.
Covered California doesn't include child dental coverage.

	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/15* + Child Dental
FEATURES	**Copay HMO Plan**	**Copay HMO Plan**
PLAN DEDUCTIBLE	$0	$0
OUT-OF-POCKET MAXIMUM Embedded	Individual – $3,000[1,28] Family – $6,000[1,28]	Individual – $3,350[1,28] Family – $6,700[1,28]
IN THE MEDICAL OFFICE Primary care visits	$10	$15
Urgent care visits	$10	$15
Specialty office visits	$20	$30
Preventive exams, vaccines (immunizations)	$0[12]	$0[12]
Prenatal care	$0[3]	$0[3]
Postpartum care	$0[3]	$0[3]
Well-child preventive care visits	$0[23]	$0[23]
Allergy injections	$5	$5
Infertility services	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$10	$15
Most laboratory tests	$20	$15
Most X-rays and diagnostic testing	$40	$30
Most MRI/CT/PET scans	$150	$75
Outpatient surgery (per procedure)	$300	$125
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$200	$150
Ambulance	$150	$150
PRESCRIPTIONS Generic drugs	$5[24] (up to a 30-day supply)	$5[24] (up to a 30-day supply)
Brand-name drugs	$15[24] (up to a 30-day supply)	$15[24] (up to a 30-day supply)
Specialty drugs	10% per prescription up to $250 maximum[24] (up to a 30-day supply)	10% per prescription up to $250 maximum[24] (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per admission	$250 per day up to 5 days per admission[26]
Skilled nursing facility care (up to 100 days per benefit period)	$250 per admission	$150 per day up to 5 days per admission[26]
MENTAL HEALTH SERVICES In the medical office	$10	$15
In the hospital	$500 per admission	$250 per day up to 5 days per admission[26]
CHEMICAL DEPENDENCY SERVICES In the medical office	$10	$15
In the hospital (detoxification only)	$500 per admission	$250 per day up to 5 days per admission[26]
OTHER Televisits	$0	$0
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)	$15 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	10%[5] (supplemental and base)	10%[6] (base only)
Certain prosthetic and orthotic devices	$0	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	1 pair of eyeglasses or contact lenses per year[7]
Pediatric vision exam	$0	$0
Adult optical (eyewear)	$175 allowance[31]	Not covered[8]
Adult vision exam (for eye refraction)	$0	$0
Home health care (up to 100 visits per year)	$0	$20 per visit
Hospice care	$0	$0

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Gold HMO plans

Plan Highlights

For effective dates 7/1/19–12/1/19
*Also available in Covered California and California*Choice*.
Covered California doesn't include child dental coverage.

	Gold 80 HMO 0/30* + Child Dental	Gold 80 HMO 500/30* + Child Dental Alt	Gold 80 HRA HMO 2250/35 + Child Dental
FEATURES	**Copay HMO Plan**	**Deductible HMO Plan**	**Deductible HMO with HRA Plan[30] (HRA can be administered through Kaiser Permanente)**
PLAN DEDUCTIBLE Embedded	$0	Individual – $500[10] Family – $1,000[10]	Individual – $2,250[10] Family – $4,500[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,200[1,28] Family – $14,400[1,28]	Individual – $7,000[1,10] Family – $14,000[1,10]	Individual – $7,550[1,10] Family – $15,100[1,10]
IN THE MEDICAL OFFICE Primary care visits	$30	$30	$35
Urgent care visits	$30	$30	$35
Specialty office visits	$55	$35	$50
Preventive exams, vaccines (immunizations)	$0[12]	$0[12]	$0[12]
Prenatal care	$0[3]	$0[3]	$0[3]
Postpartum care	$0[3]	$0[3]	$0[3]
Well-child preventive care visits	$0[23]	$0[23]	$0[23]
Allergy injections	$5	$5	$5 (after plan deductible)
Infertility services	Not covered[17]	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$30	$30	$35 (after plan deductible)
Most laboratory tests	$35	$20	25% (after plan deductible)
Most X-rays and diagnostic testing	$55	$40	25% (after plan deductible)
Most MRI/CT/PET scans	$275	$300 (after plan deductible)	25% (after plan deductible)
Outpatient surgery (per procedure)	$340	$600 (after plan deductible)	25% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$325	$250 (after plan deductible)	25% (after plan deductible)
Ambulance	$250	$250 (after plan deductible)	25% (after plan deductible)
PRESCRIPTIONS Generic drugs	$15[24] (up to a 30-day supply)	$15[24] (up to a 30-day supply)	$15[24] (up to a 30-day supply)
Brand-name drugs	$55[24] (up to a 30-day supply)	$50[24] (up to a 30-day supply)	$30[24] (up to a 30-day supply)
Specialty drugs	20% per prescription up to $250 maximum[24] (up to a 30-day supply)	20% per prescription up to $250 maximum[24] (up to a 30-day supply)	20% per prescription up to $250 maximum[24] (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission[26]	$600 per day up to 5 days per admission (after plan deductible)[26]	25% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	$300 per day up to 5 days per admission[26]	$300 per day up to 5 days per admission (after plan deductible)[26]	25% (after plan deductible)
MENTAL HEALTH SERVICES In the medical office	$30	$30	$35
In the hospital	$600 per day up to 5 days per admission[26]	$600 per day up to 5 days per admission (after plan deductible)[26]	25% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$30	$30	$35
In the hospital (detoxification only)	$600 per day up to 5 days per admission[26]	$600 per day up to 5 days per admission (after plan deductible)[26]	25% (after plan deductible)
OTHER Televisits	$0	$0	$0
Chiropractic and acupuncture	$30 per visit for physician-referred acupuncture; chiropractic not covered	$15 per visit (20 combined visits per year)	$35 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	20%[6] (base only)	20%[27] (supplemental and base)	50%[6] (base only)
Certain prosthetic and orthotic devices	$0	$0 (after plan deductible)	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	1 pair of eyeglasses or contact lenses per year[7]	1 pair of eyeglasses or contact lenses per year[7]
Pediatric vision exam	$0	$0	$0
Adult optical (eyewear)	Not covered[8]	Not covered[8]	Not covered[8]
Adult vision exam (for eye refraction)	$0	$0	$0
Home health care (up to 100 visits per year)	$30 per visit	$0	$0
Hospice care	$0	$0	$0

Refer to page 15 for the medical plan footnotes. Refer to page 16 for the child dental benefits. Refer to page 4 for HRA details.

Kaiser Permanente Silver HMO plans

Plan Highlights

For effective dates 7/1/19–12/1/19
*Also available in Covered California and California*Choice*.
Covered California doesn't include child dental coverage.

	Silver 70 HMO 1000/55* + Child Dental Alt	Silver 70 HMO 1800/55* + Child Dental Alt
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**
PLAN DEDUCTIBLE Embedded	Individual – $1,000[10] Family – $2,000[10]	Individual – $1,800[10] Family – $3,600[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,550[1,10] Family – $15,100[1,10]	Individual – $7,550[1,10] Family – $15,100[1,10]
IN THE MEDICAL OFFICE Primary care visits	$55	$55
Urgent care visits	$55	$55
Specialty office visits	$75	$75
Preventive exams, vaccines (immunizations)	$0[12]	$0[12]
Prenatal care	$0[3]	$0[3]
Postpartum care	$0[3]	$0[3]
Well-child preventive care visits	$0[23]	$0[23]
Allergy injections	$5	$5
Infertility services	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$65	$65
Most laboratory tests	$50	$50 (after plan deductible)
Most X-rays and diagnostic testing	$70	$55 (after plan deductible)
Most MRI/CT/PET scans	$350 (after plan deductible)	$350 (after plan deductible)
Outpatient surgery (per procedure)	35% (after plan deductible)	45% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	35% (after plan deductible)	45% (after plan deductible)
Ambulance	35% (after plan deductible)	45% (after plan deductible)
PRESCRIPTIONS Generic drugs	$30[24] (up to a 30-day supply)	$30[24] (up to a 30-day supply)
Brand-name drugs	$75 (after $250 drug deductible)[24] (up to a 30-day supply)	$75 (after $350 drug deductible)[24] (up to a 30-day supply)
Specialty drugs	20% per prescription up to $250 maximum (after $250 drug deductible)[24] (up to a 30-day supply)	20% per prescription up to $250 maximum (after $350 drug deductible)[24] (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	35% (after plan deductible)	45% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	35% (after plan deductible)	45% (after plan deductible)
MENTAL HEALTH SERVICES In the medical office	$55	$55
In the hospital	35% (after plan deductible)	45% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$55	$55
In the hospital (detoxification only)	35% (after plan deductible)	45% (after plan deductible)
OTHER Televisits	$0	$0
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)	$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME)	35%[6] (base only)	45%[6] (base only)
Certain prosthetic and orthotic devices	$0	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	1 pair of eyeglasses or contact lenses per year[7]
Pediatric vision exam	$0	$0
Adult optical (eyewear)	Not covered[8]	Not covered[8]
Adult vision exam (for eye refraction)	$0	$0
Home health care (up to 100 visits per year)	$0	$0
Hospice care	$0	$0

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Silver HMO plans

Plan Highlights

For effective dates 7/1/19–12/1/19
*Also available in Covered California and California*Choice*.
Covered California doesn't include child dental coverage.

	Silver 70 HMO 2000/45* + Child Dental	Silver 70 HDHP HMO 2500/20%* + Child Dental
FEATURES	**Deductible HMO Plan**	**HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)**
PLAN DEDUCTIBLE Embedded	Individual – $2,000[10] Family – $4,000[10]	Self-only – $2,500[10,32] Individual – $2,700[10,32] Family – $5,000[10,32]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,550[1,10] Family – $15,100[1,10]	Individual – $6,650[10,29] Family – $13,300[10,29]
IN THE MEDICAL OFFICE Primary care visits	$45	20% (after plan deductible)
Urgent care visits	$45	20% (after plan deductible)
Specialty office visits	$80	20% (after plan deductible)
Preventive exams, vaccines (immunizations)	$0[12]	$0[12]
Prenatal care	$0[3]	$0[4]
Postpartum care	$0[3]	$0 (after plan deductible)[16]
Well-child preventive care visits	$0[23]	$0[23]
Allergy injections	$5	20% (after plan deductible)
Infertility services	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$45	20% (after plan deductible)
Most laboratory tests	$40	20% (after plan deductible)
Most X-rays and diagnostic testing	$75	20% (after plan deductible)
Most MRI/CT/PET scans	$300	20% (after plan deductible)
Outpatient surgery (per procedure)	20%	20% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$350	20% (after plan deductible)
Ambulance	$250 (after plan deductible)	20% (after plan deductible)
PRESCRIPTIONS Generic drugs	$15 (after $200 drug deductible)[24] (up to a 30-day supply)	20% per prescription up to $250 maximum (after plan deductible)[24] (up to a 30-day supply)
Brand-name drugs	$55 (after $200 drug deductible)[24] (up to a 30-day supply)	20% per prescription up to $250 maximum (after plan deductible)[24] (up to a 30-day supply)
Specialty drugs	20% per prescription up to $250 maximum (after $200 drug deductible)[24] (up to a 30-day supply)	20% per prescription up to $250 maximum (after plan deductible)[24] (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	20% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	20% (after plan deductible)
MENTAL HEALTH SERVICES In the medical office	$45	20% (after plan deductible)
In the hospital	20% (after plan deductible)	20% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$45	20% (after plan deductible)
In the hospital (detoxification only)	20% (after plan deductible)	20% (after plan deductible)
OTHER Televisits	$0	$0 (after plan deductible)[33]
Chiropractic and acupuncture	$45 per visit for physician-referred acupuncture; chiropractic not covered	20% per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	20%[6] (base only)	20% (after plan deductible)[6] (base only)
Certain prosthetic and orthotic devices	$0	$0 (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	1 pair of eyeglasses or contact lenses per year[7]
Pediatric vision exam	$0	$0
Adult optical (eyewear)	Not covered[8]	Not covered[8]
Adult vision exam (for eye refraction)	$0	$0
Home health care (up to 100 visits per year)	$45 per visit	20% (after plan deductible)
Hospice care	$0	$0 (after plan deductible)

Refer to page 15 for the medical plan footnotes. Refer to page 16 for the child dental benefits. Refer to page 4 for HSA details.

Kaiser Permanente Bronze HMO plans

Plan Highlights

For effective dates 7/1/19–12/1/19
*Also available in Covered California and California*Choice*.
Covered California doesn't include child dental coverage.

	Bronze 60 HMO 6300/75* + Child Dental	Bronze 60 HDHP HMO 6000/40%* + Child Dental
FEATURES	**Deductible HMO Plan**	**HSA-qualified High Deductible Health Plan (HSA can be administered through Kaiser Permanente)**
PLAN DEDUCTIBLE Embedded	Individual – $6,300[10,20] Family – $12,600[10,20]	Individual – $6,000[10] Family – $12,000[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,550[1,10] Family – $15,100[1,10]	Individual – $6,650[10,29] Family – $13,300[10,29]
IN THE MEDICAL OFFICE		
Primary care visits	$75 (after plan deductible)[2]	40% (after plan deductible)
Urgent care visits	$75 (after plan deductible)[2]	40% (after plan deductible)
Specialty office visits	$105 (after plan deductible)[2]	40% (after plan deductible)
Preventive exams, vaccines (immunizations)	$0[12]	$0[12]
Prenatal care	$0[3]	$0[4]
Postpartum care	$0[3]	$0 (after plan deductible)[16]
Well-child preventive care visits	$0[23]	$0[23]
Allergy injections	$5 (after plan deductible)	40% (after plan deductible)
Infertility services	Not covered[17]	Not covered[17]
Physical, occupational, and speech therapy	$75	40% (after plan deductible)
Most laboratory tests	$40	40% (after plan deductible)
Most X-rays and diagnostic testing	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
Most MRI/CT/PET scans	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
Outpatient surgery (per procedure)	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
Ambulance	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
PRESCRIPTIONS Generic drugs	100% per prescription up to $500 maximum (after $500 drug deductible)[24] (up to a 30-day supply)	40% per prescription up to $500 maximum (after plan deductible)[24] (up to a 30-day supply)
Brand-name drugs	100% per prescription up to $500 maximum (after $500 drug deductible)[24] (up to a 30-day supply)	40% per prescription up to $500 maximum (after plan deductible)[24] (up to a 30-day supply)
Specialty drugs	100% per prescription up to $500 maximum (after $500 drug deductible)[24] (up to a 30-day supply)	40% per prescription up to $500 maximum (after plan deductible)[24] (up to a 30-day supply)
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
MENTAL HEALTH SERVICES		
In the medical office	$75 (after plan deductible)[2]	40% (after plan deductible)
In the hospital	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES		
In the medical office	$75 (after plan deductible)[2]	40% (after plan deductible)
In the hospital (detoxification only)	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
OTHER Televisits	$0	$0 (after plan deductible)[33]
Chiropractic and acupuncture	$75 per visit (after plan deductible)[2] for physician-referred acupuncture; chiropractic not covered	40% per visit (after plan deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME)	100% (up to out-of-pocket maximum)[6,20] (base only)	40% (after plan deductible)[6] (base only)
Certain prosthetic and orthotic devices	$0	$0 (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	1 pair of eyeglasses or contact lenses per year[7]
Pediatric vision exam	$0	$0
Adult optical (eyewear)	Not covered[8]	Not covered[8]
Adult vision exam (for eye refraction)	$0	$0
Home health care (up to 100 visits per year)	100% (up to out-of-pocket maximum)[20]	40% (after plan deductible)
Hospice care	$0	$0 (after plan deductible)

Refer to page 15 for the medical plan footnotes.
Refer to page 16 for the child dental benefits.
Refer to page 4 for HSA details.

Kaiser Permanente Platinum PPO insurance plans

For effective dates 7/1/19–12/1/19

Plan Highlights

	Platinum 90 PPO 0/15 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[9]**	**Non-Participating Provider Tier (out-of-network)[9]**
PLAN DEDUCTIBLE Embedded	$0	Individual – $500[10] Family – $1,000[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $3,350[11] Family – $6,700[11]	Individual – $6,700[10,11] Family – $13,400[10,11]
IN THE MEDICAL OFFICE		
Primary care visits	$15	30% (after plan deductible)
Urgent care visits	$15	30% (after plan deductible)
Specialty office visits	$30	30% (after plan deductible)
Preventive exams, vaccines (immunizations)	$0[12]	30%[12]
Prenatal care	$0[3,13,14]	30%[3,13,14]
Postpartum care	$0[3]	30%[3]
Well-child preventive care visits	$0	30%
Allergy injections	10%	30% (after plan deductible)
Infertility services	50%[15]	Not covered
Physical, occupational, and speech therapy	$15	30% (after plan deductible)
Most laboratory tests	$15	30% (after plan deductible)
Most X-rays and diagnostic testing	$30	30% (after plan deductible)
Most MRI/CT/PET scans	10%	30% (after plan deductible)
Outpatient surgery (per procedure)	10%	30% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$150	$150
Ambulance	$150	$150
PRESCRIPTIONS Generic drugs	$5[18,19] (up to a 30-day supply)	
Brand-name drugs	$15[18,19] (up to a 30-day supply)	
Specialty drugs	10% per prescription up to $250 maximum[19] (up to a 30-day supply)	
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	10%	30% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	10%	30% (after plan deductible)
MENTAL HEALTH SERVICES In the medical office	$15	30% (after plan deductible)
In the hospital	10%	30% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$15	30% (after plan deductible)
In the hospital (detoxification only)	10%	30% (after plan deductible)
OTHER Televisits	$0	$0
Chiropractic and acupuncture	$15 per visit (acupuncture services only)	30% per visit (after plan deductible) (acupuncture services only)
Certain durable medical equipment (DME)	10%[21,22] (supplemental and base)	30% (after plan deductible)[21,22] (supplemental and base)
Certain prosthetic and orthotic devices	10%	30% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	10% (after plan deductible)[7]
Pediatric vision exam	$0	$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	Not covered
Home health care (up to 100 visits per year)	10%[25]	30% (after plan deductible)[25]
Hospice care	$0	30% (after plan deductible)

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Gold PPO insurance plans

For effective dates 7/1/19–12/1/19

Plan Highlights

	Gold 80 PPO 0/30 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[9]**	**Non-Participating Provider Tier (out-of-network)[9]**
PLAN DEDUCTIBLE Embedded	$0	Individual – $1,000[10] Family – $2,000[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,200[11] Family – $14,400[11]	Individual – $14,400[10,11] Family – $28,800[10,11]
IN THE MEDICAL OFFICE Primary care visits	$30	40% (after plan deductible)
Urgent care visits	$30	40% (after plan deductible)
Specialty office visits	$55	40% (after plan deductible)
Preventive exams, vaccines (immunizations)	$0[12]	40%[12]
Prenatal care	$0[3,13,14]	40%[3,13,14]
Postpartum care	$0[3]	40%[3]
Well-child preventive care visits	$0	40%
Allergy injections	20%	40% (after plan deductible)
Infertility services	50%[15]	Not covered
Physical, occupational, and speech therapy	$30	40% (after plan deductible)
Most laboratory tests	$35	40% (after plan deductible)
Most X-rays and diagnostic testing	$55	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)	$325	$325
Ambulance	$250	$250
PRESCRIPTIONS Generic drugs	$15[18,19] (up to a 30-day supply)	
Brand-name drugs	$55[18,19] (up to a 30-day supply)	
Specialty drugs	20% per prescription up to $250 maximum[19] (up to a 30-day supply)	
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20%	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20%	40% (after plan deductible)
MENTAL HEALTH SERVICES In the medical office	$30	40% (after plan deductible)
In the hospital	20%	40% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$30	40% (after plan deductible)
In the hospital (detoxification only)	20%	40% (after plan deductible)
OTHER Televisits	$0	$0
Chiropractic and acupuncture	$30 per visit (acupuncture services only)	40% per visit (after plan deductible) (acupuncture services only)
Certain durable medical equipment (DME)	20%[21,22] (supplemental and base)	40% (after plan deductible)[21,22] (supplemental and base)
Certain prosthetic and orthotic devices	20%	40% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	20% (after plan deductible)[7]
Pediatric vision exam	$0	$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	Not covered
Home health care (up to 100 visits per year)	20%[25]	40% (after plan deductible)[25]
Hospice care	$0	40% (after plan deductible)

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Silver PPO insurance plans

For effective dates 7/1/19–12/1/19

Plan Highlights

	Silver 70 PPO 2000/45 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[9]**	**Non-Participating Provider Tier (out-of-network)[9]**
PLAN DEDUCTIBLE Embedded	Individual – $2,000[10] Family – $4,000[10]	Individual – $4,000[10] Family – $8,000[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,550[10,11] Family – $15,100[10,11]	Individual – $15,100[10,11] Family – $30,200[10,11]
IN THE MEDICAL OFFICE Primary care visits	$45	40% (after plan deductible)
Urgent care visits	$45	40% (after plan deductible)
Specialty office visits	$80	40% (after plan deductible)
Preventive exams, vaccines (immunizations)	$0[12]	40%[12]
Prenatal care	$0[3,13,14]	40%[3,13,14]
Postpartum care	$0[3]	40%[3]
Well-child preventive care visits	$0	40%
Allergy injections	20%	40% (after plan deductible)
Infertility services	50% (after plan deductible)[15]	Not covered
Physical, occupational, and speech therapy	$45	40% (after plan deductible)
Most laboratory tests	$40	40% (after plan deductible)
Most X-rays and diagnostic testing	$75	40% (after plan deductible)
Most MRI/CT/PET scans	$300	40% (after plan deductible)
Outpatient surgery (per procedure)	20%	40% (after plan deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$350	$350
Ambulance	$250 (after plan deductible)	$250 (after plan deductible)
PRESCRIPTIONS Generic drugs	$15 (after $200 drug deductible)[18,19] (up to a 30-day supply)	
Brand-name drugs	$55 (after $200 drug deductible)[18,19] (up to a 30-day supply)	
Specialty drugs	20% per prescription up to $250 maximum (after $200 drug deductible)[19] (up to a 30-day supply)	
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after plan deductible)	40% (after plan deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after plan deductible)	40% (after plan deductible)
MENTAL HEALTH SERVICES In the medical office	$45	40% (after plan deductible)
In the hospital	20% (after plan deductible)	40% (after plan deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$45	40% (after plan deductible)
In the hospital (detoxification only)	20% (after plan deductible)	40% (after plan deductible)
OTHER Televisits	$0	$0
Chiropractic and acupuncture	$45 per visit (acupuncture services only)	40% per visit (after plan deductible) (acupuncture services only)
Certain durable medical equipment (DME)	20%[21,22] (supplemental and base)	40% (after plan deductible)[21,22] (supplemental and base)
Certain prosthetic and orthotic devices	20%	40% (after plan deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	20% (after plan deductible)[7]
Pediatric vision exam	$0	$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	Not covered
Home health care (up to 100 visits per year)	$45[25]	40% (after plan deductible)[25]
Hospice care	$0	40% (after plan deductible)

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Kaiser Permanente Bronze PPO insurance plans

For effective dates 7/1/19–12/1/19

Plan Highlights

	Bronze 60 PPO 6300/75 + Child Dental	
FEATURES	**Participating Provider Tier (in-network)[9]**	**Non-Participating Provider Tier (out-of-network)[9]**
PLAN DEDUCTIBLE Embedded	Individual – $6,300[10,20] Family – $12,600[10,20]	Individual – $12,600[10] Family – $25,200[10]
OUT-OF-POCKET MAXIMUM Embedded	Individual – $7,550[10,11] Family – $15,100[10,11]	Individual – $15,100[10,11] Family – $30,200[10,11]
IN THE MEDICAL OFFICE		
Primary care visits	$75 (after plan deductible)[2]	100% (up to out-of-pocket maximum)[20]
Urgent care visits	$75 (after plan deductible)[2]	100% (up to out-of-pocket maximum)[20]
Specialty office visits	$105 (after plan deductible)[2]	100% (up to out-of-pocket maximum)[20]
Preventive exams, vaccines (immunizations)	$0[12]	40%[12]
Prenatal care	$0[3,13,14]	40%[3,13,14]
Postpartum care	$0[3]	40%[3]
Well-child preventive care visits	$0	40%
Allergy injections	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
Infertility services	100% (up to out-of-pocket maximum)[15, 20]	Not covered
Physical, occupational, and speech therapy	$75	100% (up to out-of-pocket maximum)[20]
Most laboratory tests	$40	100% (up to out-of-pocket maximum)[20]
Most X-rays and diagnostic testing	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
Most MRI/CT/PET scans	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
Outpatient surgery (per procedure)	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
EMERGENCY SERVICES		
Emergency Department visits (waived if admitted directly to hospital)	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
Ambulance	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
PRESCRIPTIONS		
Generic drugs	100% per prescription up to $500 maximum (after $500 drug deductible)[18,19] (up to a 30-day supply)	
Brand-name drugs	100% per prescription up to $500 maximum (after $500 drug deductible)[18,19] (up to a 30-day supply)	
Specialty drugs	100% per prescription up to $500 maximum (after $500 drug deductible)[19] (up to a 30-day supply)	
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
Skilled nursing facility care (up to 100 days per benefit period)	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
MENTAL HEALTH SERVICES		
In the medical office	$75 (after plan deductible)[2]	100% (up to out-of-pocket maximum)[20]
In the hospital	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
CHEMICAL DEPENDENCY SERVICES		
In the medical office	$75 (after plan deductible)[2]	100% (up to out-of-pocket maximum)[20]
In the hospital (detoxification only)	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
OTHER		
Televisits	$0	$0
Chiropractic and acupuncture	$75 per visit (after plan deductible)[2] (acupuncture services only)	100% per visit (up to out-of-pocket maximum)[20] (acupuncture services only)
Certain durable medical equipment (DME)	100% (up to out-of-pocket maximum)[20,21,22] (supplemental and base)	100% (up to out-of-pocket maximum)[20,21,22] (supplemental and base)
Certain prosthetic and orthotic devices	100% (up to out-of-pocket maximum)[20]	100% (up to out-of-pocket maximum)[20]
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[7]	100% (up to out-of-pocket maximum)[7, 20]
Pediatric vision exam	$0	$0 (after plan deductible)
Adult optical (eyewear)	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	Not covered
Home health care (up to 100 visits per year)	100% (up to out-of-pocket maximum)[20,25]	100% (up to out-of-pocket maximum)[20,25]
Hospice care	$0	100% (up to out-of-pocket maximum)[20]

Refer to page 15 for the medical plan footnotes.

Refer to page 16 for the child dental benefits.

Footnotes for medical plans

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

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

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

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

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

[3]Scheduled prenatal visits and the first postpartum visit.

[4]Scheduled prenatal visits.

[5]Supplemental coverage: $2,000 benefit limit per year.

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

[7]Under age 19.

[8]Kaiser Permanente members are entitled to a discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts can't be combined with any other Health Plan vision benefit. The discounts won't apply to any sale, promotion, or packaged eyewear program; for any contact lens extended purchase agreement; or to low-vision aids or devices. Visit **kp2020.org** for Kaiser Permanente optical locations.

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

[10]This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible or out-of-pocket maximum is satisfied. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[28]This plan has an embedded out-of-pocket maximum. Individual family members aren't subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of-pocket maximum is met.

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

[30]Groups selecting the Gold HRA HMO 2250/35 Deductible HMO with HRA plan must establish and fund an HRA for each enrolled employee. The allowable funding range is $200 to $500 per employee. If the group covers dependents, the allowable funding range per family is $400 to $1,000.

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

[32]Self-only: a family of 1 member.
Individual: each member in a family of 2 or more members.
Family: entire family of 2 or more members.

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

Dental plans

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

Child dental benefits

For effective dates 7/1/19–12/1/19

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

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

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

DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

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

For effective dates 7/1/19–12/1/19

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*	LIMITATIONS
SERVICE	**PLAN PAYS†**	**PLAN PAYS†**	**PLAN PAYS†**	**PLAN PAYS†**	
NO DEDUCTIBLE APPLIES TO THESE PROCEDURES.					
Exam	100%	100%	100%	100%	Twice a year
Bitewing X-rays X-rays of the top and bottom molars and premolars to show decay between teeth or under fillings	100%	100%	100%	100%	Twice a year for children through age 18, or once a year for adults ages 19 and over
Other X-rays	80%	80%	80%	80%	Full-mouth X-rays, single X-rays, and panographic X-rays once in any five-year period
Prophylaxis A professional cleaning to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	100%	100%	100%	Twice a year
Fluoride treatments A treatment with a chemical compound that prevents cavities and makes the tooth surface stronger so the teeth can resist decay	100%	100%	100%	100%	Only for children through age 18, twice a year
DEDUCTIBLES APPLY TO PROCEDURES UNDER PLANS D, E, AND E WITH ORTHODONTICS.					
Deductible	No deductible	$25	$25	$25	Per person, per year, up to a family maximum of $75 per year
Benefit maximum	$500	$1,000	$1,000	$1,000	The benefit maximum represents the total amount paid by the plan per person, per year
Palliative care Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms; the goal is to prevent and relieve suffering and improve quality of life	80%	80%	80%	80%	Usual, customary, and reasonable
Denture relines	Not covered	80%	80%	80%	Twice a year (limited to two upper, two lower, or any combination)‡
Space maintainers	100%	100%	100%	100%	Usual, customary, and reasonable
Fillings	80%	80%	80%	80%	Usual, customary, and reasonable
Stainless steel crowns	80%	80%	80%	80%	Primary teeth only
Endodontics A dental specialty concerned with treatment of the root and nerve of the tooth	Not covered	80%	80%	80%	Usual, customary, and reasonable
Periodontics A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	Not covered	80%	80%	80%	Usual, customary, and reasonable
Oral surgery	Not covered	80%	80%	80%	Usual, customary, and reasonable
Crowns and cast restorations The artificial covering of a tooth with metal porcelain or porcelain fused to metal; covers teeth that are weakened by decay or severely damaged or chipped	Not covered	Not covered	50%	50%	Includes replacements after five years, but only if originally covered by KPIC dental plan
Prosthodontics A dental specialty concerned with restoration and/or replacement of missing teeth with artificial materials	Not covered	Not covered	50%	50%	Standard removable prosthetic appliance (includes replacements after five years, but only if originally covered by KPIC dental plan)
Orthodontics A dental specialty concerned with straightening or moving misaligned teeth and/or jaws with braces and/or surgery	Not covered	Not covered	Not covered	50%	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.)

*Plan E with Orthodontics requires at least 10 subscribers.
†Benefits payable will be based on the lesser of the usual, customary, and reasonable fees or the fees actually charged.
‡Limitation applies only to Plan D.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Kaiser Permanente Insurance Company
KPIC PPO dental plans

For effective dates 7/1/19–12/1/19

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 D 1500		PPO E 1000		PPO E 1500		LIMITATIONS
SERVICE	PLAN PAYS* (PPO NETWORK)	PLAN PAYS (OUT-OF-NETWORK)	PLAN PAYS* (PPO NETWORK)	PLAN PAYS (OUT-OF-NETWORK)	PLAN PAYS* (PPO NETWORK)	PLAN PAYS (OUT-OF-NETWORK)	
NO DEDUCTIBLE APPLIES TO THESE PROCEDURES.							
Exam	100%	50%	100%	50%	100%	50%	Twice a year
Bitewing X-rays X-rays of the top and bottom molars and premolars to show decay between teeth or under fillings	100%	50%	100%	50%	100%	50%	Twice a year for children through age 18, or once a year for adults ages 19 and over
Other X-rays	80%	50%	80%	50%	80%	50%	Full-mouth X-rays, single X-rays, and panographic X-rays once in any five-year period
Prophylaxis A professional cleaning to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	50%	100%	50%	100%	50%	Twice a year
Fluoride treatments A treatment with a chemical compound that prevents cavities and makes the tooth surface stronger so the teeth can resist decay	100%	50%	100%	50%	100%	50%	Only for children through age 18, twice a year
DEDUCTIBLES APPLY TO PROCEDURES BELOW.							
Deductible	$25	$50	$25	$50	$25	$50	Per person, per year, up to a family maximum of $75 (in-network) and $150 (out-of-network)
Benefit maximum	$1,500	$1,500	$1,000	$1,000	$1,500	$1,500	Benefit maximum represents the total amount paid by the plan per person, per year
Palliative care Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms; the goal is to prevent and relieve suffering and improve quality of life	80%	50%	80%	50%	80%	50%	
Denture relines	80%	50%	80%	50%	80%	50%	Twice a year
Space maintainers	100%	50%	100%	50%	100%	50%	
Fillings	80%	50%	80%	50%	80%	50%	
Stainless steel crowns	80%	50%	80%	50%	80%	50%	Primary teeth only
Endodontics A dental specialty concerned with treatment of the root and nerve of the tooth	80%	50%	80%	50%	80%	50%	
Periodontics A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	80%	50%	80%	50%	80%	50%	
Oral surgery	80%	50%	80%	50%	80%	50%	
Crowns and cast restorations The artificial covering of a tooth with metal porcelain or porcelain fused to metal; covers teeth that are weakened by decay or severely damaged or chipped	Not covered	Not covered	50%	50%	50%	50%	Includes 1 replacement in any 5-year period, but only if originally covered by KPIC dental plan
Prosthodontics A dental specialty concerned with restoration and/or replacement of missing teeth with artificial material	Not covered	Not covered	50%	50%	50%	50%	Standard removable prosthetic appliances (includes one replacement in any 5-year period, but only if originally covered by KPIC dental plan)
Orthodontics A dental specialty concerned with straightening or moving misaligned teeth and/or jaws with braces and/or surgery	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

*Benefits payable will be based on the maximum allowable charge.

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

DeltaCare HMO plans

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

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®

Important information for the KPIC Fee-for-Service (Premier) and PPO dental insurance plans

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

- Any treatment or procedure not listed as covered.
- Charges in excess of the maximum allowable charge.
- Services for injuries or conditions covered under workers' compensation or employer's liability laws.
- 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, premedication, or pain relievers.
- Experimental procedures.
- Hospital costs or extra charges for hospital treatment.
- Anesthesia (except general anesthesia for oral surgery).
- Extra-oral grafts, implants, or implant removal.
- Treatment related to the temporomandibular joint (TMJ).
- Plaque-control programs, oral hygiene, or dietary instructions.
- Orthodontic treatment, except for eligible dependent children under Plan E with Orthodontics.
- Treatment plans that are more expensive than those customarily provided, or specialized techniques used instead of standard procedures; for example, a precision denture where a standard denture would suffice.
- Pit and fissure sealants, except for first molars of children through age 8 and second molars for children through age 15. The molar must have no decay and no restoration, and the occlusal surface must be intact. Coverage doesn't include the repair or replacement of a sealant on any tooth within 3 years of application.
- Services provided to the covered person by any federal or state governmental agency or provided without cost to the covered person by any municipality, county, or other political subdivision, except Medi-Cal benefits.
- Charges by any hospital or other surgical treatment facility, or any additional fees charged by the dentist for treatment in any such facility.
- Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants.
- Replacement of existing restoration for any purpose other than active tooth decay.
- Intravenous sedation, occlusal guards, or complete occlusal adjustment.
- Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
- Hypnosis.
- Charges for completion of forms.
- Charges for speech therapy.
- Charges for lost or stolen appliances.
- Services for which no charge is normally made in the absence of insurance.

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.

DeltaCare HMO 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.

Exclusions of benefits for the DeltaCare HMO dental plans

Exclusions

- 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®

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Chiropractic and acupuncture

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

- Platinum 90 HMO 0/10 + Child Dental Alt
- Gold 80 HMO 500/30 + Child Dental Alt
- Silver 70 HMO 1000/55 + Child Dental Alt
- Silver 70 HMO 1800/55 + Child Dental Alt

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

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

Services

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

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

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

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

Participating chiropractors and acupuncturists

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

(continues on page 23)

(continued from page 22)

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

How to obtain covered services

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

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

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

Getting assistance

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

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

Dispute resolution

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

Durable medical equipment (DME) benefits

All Kaiser Permanente small business plans cover "base" DME items that are a part of the essential health benefits. The following plans also cover "supplemental" DME items that aren't part of the essential health benefits.

Metal plans with supplemental DME ($2,000 annual benefit maximum)

- Platinum 90 HMO 0/10 + Child Dental Alt
- Gold 80 HMO 500/30 + Child Dental Alt
- Platinum 90 PPO 0/15 + Child Dental
- Gold 80 PPO 0/30 + Child Dental
- Silver 70 PPO 2000/45 + Child Dental
- Bronze 60 PPO 6300/75 + Child Dental

Sample list of DME covered items*

Base DME coverage

- Canes and crutches
- Bone stimulator
- Cervical traction, over door
- Nebulizers and supplies
- Infusion pumps and supplies
- Blood glucose monitors

Supplemental DME coverage

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

*This isn't a complete list. 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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Small Business
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