PLATINUM 90 HMO 0/10* + CHILD DENTAL ALT†

Copay HMO Plan

The abbreviation "ALT" in the plan names designates Kaiser Permanente developed "alternate" plans that supplement those available through Covered California for Small Business. Alternate plans are available at the Platinum, Gold, and Silver levels and provide a broader range of plan benefits, including chiropractic/acupuncture, for small businesses with 1–100 employees.

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	$0
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $4,000[1,2] Family — $8,000[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$10
Urgent care visits	$10
Specialty office visits	$20
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5
Infertility services	Not covered[6]
Physical, occupational, and speech therapy	$10
Most laboratory tests	$20
Most X-rays and diagnostic testing	$40
Most MRI/CT/PET scans	$150
Outpatient surgery (per procedure)	$300
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	$200
Ambulance	$150
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$5[7]
Brand-name drugs (up to a 30-day supply)	$15[7]
Specialty drugs (up to a 30-day supply)	10% per prescription up to $250 maximum[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per admission
Skilled nursing facility care (up to 100 days per benefit period)	$250 per admission
MENTAL HEALTH SERVICES	
In the medical office	$10
In the hospital	$500 per admission
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$10
In the hospital (detoxification only)	$500 per admission
OTHER	
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	10%[8]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[9]
Pediatric vision exam	$0
Adult optical (eyewear)	$175 allowance[10]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$0
Hospice care	$0

[1]This plan has an embedded out-of-pocket maximum. 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.

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

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

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

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

[7]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; please refer to the *Evidence of Coverage* for detailed information about prescription drug copays. Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drug list, please call our Member Service Contact Center.

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

[9]Under age 19

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

KAISER PERMANENTE®

PLATINUM 90 HMO 0/15* + CHILD DENTAL

Copay HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	$0
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $4,000[1,2] Family — $8,000[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$15
Urgent care visits	$15
Specialty office visits	$40
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5
Infertility services	Not covered[6]
Physical, occupational, and speech therapy	$15
Most laboratory tests	$20
Most X-rays and diagnostic testing	$40
Most MRI/CT/PET scans	$150
Outpatient surgery (per procedure)	$290
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	$150
Ambulance	$150
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$5[7]
Brand-name drugs (up to a 30-day supply)	$15[7]
Specialty drugs (up to a 30-day supply)	10% per prescription up to $250 maximum[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$290 per day up to 5 days per admission[8]
Skilled nursing facility care (up to 100 days per benefit period)	$150 per day up to 5 days per admission[8]
MENTAL HEALTH SERVICES	
In the medical office	$15
In the hospital	$290 per day up to 5 days per admission[8]
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$15
In the hospital (detoxification only)	$290 per day up to 5 days per admission[8]
OTHER	
Chiropractic and acupuncture	$15 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	10%[9]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[10]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[11]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$20 per day
Hospice care	$0

[1]This plan has an embedded out-of-pocket maximum. 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.

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

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

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

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

[7]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; please refer to the *Evidence of Coverage* for detailed information about prescription drug copays. Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drug list, please call our Member Service Contact Center.

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

[9]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.

[10]Under age 19

[11]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

KAISER PERMANENTE®

GOLD 80 HMO 0/30* + CHILD DENTAL

Copay HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	$0
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $6,750[1,2] Family — $13,500[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$30
Urgent care visits	$30
Specialty office visits	$55
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5
Infertility services	Not covered[6]
Physical, occupational, and speech therapy	$30
Most laboratory tests	$35
Most X-rays and diagnostic testing	$55
Most MRI/CT/PET scans	$275
Outpatient surgery (per procedure)	$655
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	$325
Ambulance	$250
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$15[7]
Brand-name drugs (up to a 30-day supply)	$55[7]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$655 per day up to 5 days per admission[8]
Skilled nursing facility care (up to 100 days per benefit period)	$300 per day up to 5 days per admission[8]
MENTAL HEALTH SERVICES	
In the medical office	$30
In the hospital	$655 per day up to 5 days per admission[8]
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$30
In the hospital (detoxification only)	$655 per day up to 5 days per admission[8]
OTHER	
Chiropractic and acupuncture	$30 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	20%[9]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[10]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[11]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$30 per day
Hospice care	$0

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

[2]This plan has an embedded out-of-pocket maximum. 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.

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

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

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

[7]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; please refer to the *Evidence of Coverage* for detailed information about prescription drug copays. Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drug list, please call our Member Service Contact Center.

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

[9]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.

[10]Under age 19

[11]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

KAISER PERMANENTE®

GOLD 80 HMO 500/35* + CHILD DENTAL ALT†

Deductible HMO Plan

†The abbreviation "ALT" in the plan names designates Kaiser Permanente developed "alternate" plans that supplement those available through Covered California for Small Business. Alternate plans are available at the Platinum, Gold, and Silver levels and provide a broader range of plan benefits, including chiropractic/acupuncture, for small businesses with 1–100 employees.

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	Individual — $500[1] Family — $1,000[1]
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $6,750[1,2] Family — $13,500[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$35
Urgent care visits	$35
Specialty office visits	$35
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5
Infertility services	Not covered[6]
Physical, occupational, and speech therapy	$35
Most laboratory tests	$20
Most X-rays and diagnostic testing	$40
Most MRI/CT/PET scans	$250
Outpatient surgery (per procedure)	$600 (after deductible)
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	$250 (after deductible)
Ambulance	$250 (after deductible)
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$15[7]
Brand-name drugs (up to a 30-day supply)	$50[7]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission (after deductible)[8]
Skilled nursing facility care (up to 100 days per benefit period)	$250 per day up to 5 days per admission (after deductible)[8]
MENTAL HEALTH SERVICES	
In the medical office	$35
In the hospital	$600 per day up to 5 days per admission (after deductible)[8]
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$35
In the hospital (detoxification only)	$600 per day up to 5 days per admission (after deductible)[8]
OTHER	
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME) (supplemental and base)	20%[9]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[10]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[11]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$0
Hospice care	$0

[1]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 when the family deductible is satisfied. 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.

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

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

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

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

[7]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; please refer to the *Evidence of Coverage* for detailed information about prescription drug copays. Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drug list, please call our Member Service Contact Center.

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

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

[10]Under age 19

[11]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

KAISER PERMANENTE®

SILVER 70 HMO 1000/50* + CHILD DENTAL ALT†

Deductible HMO Plan

†The abbreviation "ALT" in the plan names designates Kaiser Permanente developed "alternate" plans that supplement those available through Covered California for Small Business. Alternate plans are available at the Platinum, Gold, and Silver levels and provide a broader range of plan benefits, including chiropractic/acupuncture, for small businesses with 1–100 employees.

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	Individual — $1,000[1] Family — $2,000[1]
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $6,750[1,2] Family — $13,500[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$50
Urgent care visits	$50
Specialty office visits	$50
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5
Infertility services	Not covered[6]
Physical, occupational, and speech therapy	$50
Most laboratory tests	$50
Most X-rays and diagnostic testing	$50
Most MRI/CT/PET scans	30% (after deductible)
Outpatient surgery (per procedure)	30% (after deductible)
EMERGENCY SERVICES	
Emergency Department visits	30% (after deductible)
Ambulance	30% (after deductible)
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$25[7]
Brand-name drugs (up to a 30-day supply)	$50 (after $200 drug deductible)[7]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after $200 drug deductible)[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	30% (after deductible)
MENTAL HEALTH SERVICES	
In the medical office	$50
In the hospital	30% (after deductible)
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$50
In the hospital (detoxification only)	30% (after deductible)
OTHER	
Chiropractic and acupuncture	$15 per visit (20 combined visits per year)
Certain durable medical equipment (DME) (base only)	30%[8]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[9]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[10]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$0
Hospice care	$0

[1]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 when the family deductible is satisfied. 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.

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

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

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

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

[7]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.

[8]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.

[9]Under age 19

[10]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

KAISER PERMANENTE®

For effective dates January 1–December 1, 2017
*ALSO AVAILABLE IN COVERED CALIFORNIA

SILVER 70 HMO 2000/45* + CHILD DENTAL

Deductible HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	Individual — $2,000[1] Family — $4,000[1]
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $6,800[1,2] Family — $13,600[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$45
Urgent care visits	$45
Specialty office visits	$75
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5
Infertility services	Not covered[6]
Physical, occupational, and speech therapy	$45
Most laboratory tests	$40
Most X-rays and diagnostic testing	$70
Most MRI/CT/PET scans	$300
Outpatient surgery (per procedure)	20%
EMERGENCY SERVICES	
Emergency Department visits (waived if admitted directly to hospital)	$350
Ambulance	$250 (after deductible)
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$15[7]
Brand-name drugs (up to a 30-day supply)	$55 (after $250 drug deductible)[7]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after $250 drug deductible)[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after deductible)
Skilled nursing facility care (up to 30 days per benefit period)	20% (after deductible)
MENTAL HEALTH SERVICES	
In the medical office	$45
In the hospital	20% (after deductible)
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$45
In the hospital (detoxification only)	20% (after deductible)
OTHER	
Chiropractic and acupuncture	$45 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	20%[8]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[9]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[10]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$45 per day
Hospice care	$0

[1]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 when the family deductible is satisfied. 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.

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

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

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

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

[7]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.

[8]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.

[9]Under age 19

[10]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

KAISER PERMANENTE®

For effective dates January 1–December 1, 2017

*ALSO AVAILABLE IN COVERED CALIFORNIA

SILVER 70 HDHP HMO 2000/20%* + CHILD DENTAL

HSA-qualified High Deductible Health Plan
(HSA can be administered through Kaiser Permanente)

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	Self-only — $2,000[1,2] Individual — $2,600[1,2] Family — $4,000[1,2]
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $6,550[1,3] Family — $13,100[1,3]
IN THE MEDICAL OFFICE	
Primary care visits	20% (after deductible)
Urgent care visits	20% (after deductible)
Specialty office visits	20% (after deductible)
Preventive exams, vaccines (immunizations)	$0[4]
Prenatal care	$0[5]
Postpartum care	$0 (after deductible)[6]
Well-child preventive care visits	$0[7]
Allergy injections	20% (after deductible)
Infertility services	Not covered[8]
Physical, occupational, and speech therapy	20% (after deductible)
Most laboratory tests	20% (after deductible)
Most X-rays and diagnostic testing	20% (after deductible)
Most MRI/CT/PET scans	20% (after deductible)
Outpatient surgery (per procedure)	20% (after deductible)
EMERGENCY SERVICES	
Emergency Department visits	20% (after deductible)
Ambulance	20% (after deductible)
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after deductible)[9]
Brand-name drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after deductible)[9]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum (after deductible)[9]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after deductible)
MENTAL HEALTH SERVICES	
In the medical office	20% (after deductible)
In the hospital	20% (after deductible)
CHEMICAL DEPENDENCY SERVICES	
In the medical office	20% (after deductible)
In the hospital (detoxification only)	20% (after deductible)
OTHER	
Chiropractic and acupuncture	20% per visit (after deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	20% (after deductible)[10]
Certain prosthetic and orthotic devices	$0 (after deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[11]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[12]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	20% (after deductible)
Hospice care	$0 (after deductible)

[1]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 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.

[2]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

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

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

[5]Scheduled prenatal visits

[6]First postpartum visit only covered at no charge.

[7]Well-child visits through age 23 months

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

[9]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.

[10]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.

[11]Under age 19

[12]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

Small Business
60575210 July 2017

KAISER PERMANENTE®

GOLD 80 HRA HMO 2000/30 + CHILD DENTAL

Deductible HMO with HRA Plan[11]

(HRA can be administered through Kaiser Permanente)

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	Individual — $2,000[1] Family — $4,000[1]
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $6,500[1,2] Family — $13,000[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	$30
Urgent care visits	$30
Specialty office visits	$30
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0[4]
Well-child preventive care visits	$0[5]
Allergy injections	$5 (after deductible)
Infertility services	Not covered[6]
Physical, occupational, and speech therapy	$30 (after deductible)
Most laboratory tests	20% (after deductible)
Most X-rays and diagnostic testing	20% (after deductible)
Most MRI/CT/PET scans	20% (after deductible)
Outpatient surgery (per procedure)	20% (after deductible)
EMERGENCY SERVICES	
Emergency Department visits	20%
Ambulance	20% (after deductible)
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	$15[7]
Brand-name drugs (up to a 30-day supply)	$30[7]
Specialty drugs (up to a 30-day supply)	20% per prescription up to $250 maximum[7]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% (after deductible)
MENTAL HEALTH SERVICES	
In the medical office	$30
In the hospital	20% (after deductible)
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$30
In the hospital (detoxification only)	20% (after deductible)
OTHER	
Chiropractic and acupuncture	$30 per visit for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	50%[8]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[9]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[10]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	$0
Hospice care	$0

[1]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 when the family deductible is satisfied. 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.

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

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

[4]Scheduled prenatal visits and the first postpartum visit

[5]Well-child visits through age 23 months

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

[7]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; please refer to the *Evidence of Coverage* for detailed information about prescription drug copays. Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drug list, please call our Member Service Contact Center.

[8]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.

[9]Under age 19

[10]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

[11]Groups selecting the Gold HRA 2000/30 Deductible HMO with HRA plan must establish and fund an HRA for each enrolled employee. The allowable funding range is $250 to $600 per employee. If the group covers dependents, the allowable funding range per family is $500 to $1,200.

KAISER PERMANENTE®

For effective dates January 1–December 1, 2017

*ALSO AVAILABLE IN COVERED CALIFORNIA

BRONZE 60 HDHP HMO 4800/40%* + CHILD DENTAL

HSA-qualified High Deductible Health Plan
(HSA can be administered through Kaiser Permanente)

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	Individual — $4,800[1] Family — $9,600[1]
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $6,550[1,2] Family — $13,100[1,2]
IN THE MEDICAL OFFICE	
Primary care visits	40% (after deductible)
Urgent care visits	40% (after deductible)
Specialty office visits	40% (after deductible)
Preventive exams, vaccines (immunizations)	$0[3]
Prenatal care	$0[4]
Postpartum care	$0 (after deductible)[5]
Well-child preventive care visits	$0[6]
Allergy injections	40% (after deductible)
Infertility services	Not covered[7]
Physical, occupational, and speech therapy	40% (after deductible)
Most laboratory tests	40% (after deductible)
Most X-rays and diagnostic testing	40% (after deductible)
Most MRI/CT/PET scans	40% (after deductible)
Outpatient surgery (per procedure)	40% (after deductible)
EMERGENCY SERVICES	
Emergency Department visits	40% (after deductible)
Ambulance	40% (after deductible)
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	40% per prescription up to $500 maximum (after deductible)[8]
Brand-name drugs (up to a 30-day supply)	40% per prescription up to $500 maximum (after deductible)[8]
Specialty drugs (up to a 30-day supply)	40% per prescription up to $500 maximum (after deductible)[8]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	40% (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	40% (after deductible)
MENTAL HEALTH SERVICES	
In the medical office	40% (after deductible)
In the hospital	40% (after deductible)
CHEMICAL DEPENDENCY SERVICES	
In the medical office	40% (after deductible)
In the hospital (detoxification only)	40% (after deductible)
OTHER	
Chiropractic and acupuncture	40% per visit (after deductible) for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	40% (after deductible)[9]
Certain prosthetic and orthotic devices	$0 (after deductible)
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[10]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[11]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	40% (after deductible)
Hospice care	$0 (after deductible)

[1]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 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.
[2]Out-of-pocket maximum is the maximum amount an individual or family will pay for all covered services in a year.
[3]Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
[4]Scheduled prenatal visits
[5]First postpartum visit only covered at no charge.
[6]Well-child visits through age 23 months
[7]Infertility benefits can be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.
[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]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.
[10]Under age 19
[11]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

Small Business
60575308 July 2017

KAISER PERMANENTE®

For effective dates January 1–December 1, 2017

*ALSO AVAILABLE IN COVERED CALIFORNIA

BRONZE 60 HMO 6300/75* + CHILD DENTAL

Deductible HMO Plan

FEATURES	MEMBER PAYS
PLAN DEDUCTIBLE	
Embedded	Individual — $6,300[1,2] Family — $12,600[1,2]
OUT-OF-POCKET MAXIMUM	
Embedded	Individual — $6,800[1,3] Family — $13,600[1,3]
IN THE MEDICAL OFFICE	
Primary care visits	$75 (after deductible)[4]
Urgent care visits	$75 (after deductible)[4]
Specialty office visits	$105 (after deductible)[4]
Preventive exams, vaccines (immunizations)	$0[5]
Prenatal care	$0[6]
Postpartum care	$0[6]
Well-child preventive care visits	$0[7]
Allergy injections	$5 (after deductible)
Infertility services	Not covered[8]
Physical, occupational, and speech therapy	$75
Most laboratory tests	$40
Most X-rays and diagnostic testing	100% (up to out-of-pocket maximum)[2]
Most MRI/CT/PET scans	100% (up to out-of-pocket maximum)[2]
Outpatient surgery (per procedure)	100% (up to out-of-pocket maximum)[2]
EMERGENCY SERVICES	
Emergency Department visits	100% (up to out-of-pocket maximum)[2]
Ambulance	100% (up to out-of-pocket maximum)[2]
PRESCRIPTIONS	
Generic drugs (up to a 30-day supply)	100% per prescription up to $500 maximum (after $500 drug deductible)[9]
Brand-name drugs (up to a 30-day supply)	100% per prescription up to $500 maximum (after $500 drug deductible)[9]
Specialty drugs (up to a 30-day supply)	100% per prescription up to $500 maximum (after $500 drug deductible)[9]
HOSPITAL CARE	
Physicians' services, room and board, tests, medications, supplies, therapies, birth services	100% (up to out-of-pocket maximum)[2]
Skilled nursing facility care (up to 100 days per benefit period)	100% (up to out-of-pocket maximum)[2]
MENTAL HEALTH SERVICES	
In the medical office	$75 (after deductible)[4]
In the hospital	100% (up to out-of-pocket maximum)[2]
CHEMICAL DEPENDENCY SERVICES	
In the medical office	$75 (after deductible)[4]
In the hospital (detoxification only)	100% (up to out-of-pocket maximum)[2]
OTHER	
Chiropractic and acupuncture	$75 per visit (after deductible)[4] for physician-referred acupuncture; chiropractic not covered
Certain durable medical equipment (DME) (base only)	100% (up to out-of-pocket maximum)[2,10]
Certain prosthetic and orthotic devices	$0
Pediatric optical (eyewear)	1 pair of eyeglasses or contact lenses per year[11]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[12]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per year)	100% (up to out-of-pocket maximum)[2]
Hospice care	$0

[1]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 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.
[2]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.
[3]Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year.
[4]Deductible is waived for first three visits combined for non-preventive primary care, specialty care, other practitioner care, urgent care, and mental/behavioral health and substance use disorder outpatient services.
[5]Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam.
[6]Scheduled prenatal visits and the first postpartum visit
[7]Well-child visits through age 23 months
[8]Infertility benefits can be added to this plan for an additional cost. For more information, contact your broker or Kaiser Permanente representative.
[9]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.
[10]Please refer to the *Evidence of Coverage* for information on what is included in your DME benefit. Coverage is limited.
[11]Under age 19
[12]Kaiser Permanente members are entitled to a 20% discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

Small Business
60575208 July 2017

KAISER PERMANENTE®

Chiropractic and acupuncture

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

- Platinum 90 HMO 0/10 + Child Dental
- Gold 80 HMO 500/35 + Child Dental
- Silver 70 HMO 1000/50 + Child Dental

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

contracts with participating acupuncturists to provide acupuncture care (including adjunctive therapies, such as acupressure, cupping, 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 are not 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*.

American Specialty Health Plans of California

KAISER PERMANENTE®

2017 durable medical equipment (DME) benefits

All Kaiser Permanente Small Business plans cover "base" durable medical equipment items that are essential health benefits. The following plans also cover "supplemental" durable medical equipment items that are not essential health benefits.

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

METAL PLANS

- Platinum 90 HMO 0/10 + Child Dental Alt
- Platinum 90 PPO 0/15 + Child Dental
- Gold 80 HMO 500/35 + Child Dental Alt
- Gold 80 PPO 0/30 + Child Dental
- Silver 70 PPO 2000/45 + Child Dental
- Bronze 60 PPO 6300/75 + Child Dental

NON-METAL PLANS

- $5 copay
- $15 copay
- $20 copay
- $35 POS (participating provider and non-participating provider tiers only)
- $40/$1,000 PPO
- $40/$2,600 PPO + HSA

DME coverage examples*

BASE DME COVERAGE

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

SUPPLEMENTAL DME COVERAGE

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

*This is not a complete list. To find out whether a particular item is included in our durable medical equipment formulary, please call our Member Service Contact Center at 800-464-4000 or 711 (TTY for the hearing/speech impaired). 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*.

KAISER PERMANENTE®

60521308 September 2016

CHILD DENTAL PLAN FOR KAISER PERMANENTE HMO MEDICAL PLANS

Child dental services is one of the essential health benefits required to be provided in conjunction with your Affordable Care Act (ACA) metal medical plan(s). When employees and their dependents enroll in the HMO medical plan(s) you've chosen, we will also enroll them in a separate child dental plan underwritten by Delta Dental of California.

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

Important information

- To find a dentist, please call Delta Dental at **800-422-4234.**
- You choose a Delta Dental dentist for each child. If you don't choose a dentist, we assign one to you.
- As soon as you receive your welcome kit, you can schedule an appointment. You can change your selected network dentist at any time by telephone. Changes received by the 21st of the month will be effective the first day of the following month.
- If you require specialty care, your Delta Dental dentist will coordinate it for you.

*Orthodontics includes medically necessary orthodontia only.

DELTA DENTAL®
Delta Dental Plan of California
deltadentalins.com

KAISER PERMANENTE®

KAISER PERMANENTE 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 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
1 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 1 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: 1 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 **kp.org/2020.**

For further detailed information on pediatric vision, refer to your *Combined Disclosure Form and Evidence of Coverage*.

KAISER PERMANENTE®