KAISER PERMANENTE®

Small Business
CALIFORNIA

Plan comparison guide

Kaiser Permanente for small businesses ■ For effective dates January 1-December 1, 2026

This is a high level comparison guide to compare your current grandfathered (nonmetal) plan with a metal plan.

In this guide, you can see how certain benefits and cost sharing have changed from a grandfathered (nonmetal) plan to a metal plan.

Although there are different benefits, out-of-pocket expenses, and premiums with the grandfathered (nonmetal) plans, the metal plans offer a number of robust features to help your employees get richer benefits, such as coverage for preventive care visits, essential health benefits, and more.

If you have any questions, please call Account Management Support Team **800-790-4661, option 3**

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$5 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$5 Copayment HMO	Platinum 90 HMO 0/10 PCP + Child Dental Alt*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$1,500/$3,000	$3,000/$6,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$5	$10
Specialty office visits	$5	$20
Urgent care visits	$5	$10
Most laboratory tests	$10	$20
Most X-rays and diagnostic testing	$10	$40
Outpatient surgery per procedure	$5	$300
PRESCRIPTIONS Generic drugs	$5 (up to a 100-day supply; does not apply to out-of-pocket maximum)	$5 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$15 (up to a 100-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	10% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$0	$500 per admission
OTHER Certain durable medical equipment (DME)	20% (base coverage, plus supplemental coverage up to $2,000 per year)	10% (base coverage, plus supplemental coverage up to $2,000 per year combined)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Covered[1]	Not covered[2]
Adult optical (eyewear)	$150 allowance (every 24 months)	$175 allowance
Pediatric optical (eyewear)	$150 allowance (every 24 months)	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Benefits payable for diagnosis and treatment of infertility and fertility services will be covered at the same cost-sharing as base medical service. Invitro fertilization is covered.

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

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$15 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$15 Copayment HMO	Platinum 90 HMO 0/20 PCP + Child Dental*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$2,500/$5,000	$4,500/$9,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$15	$20
Specialty office visits	$15	$30
Urgent care visits	$15	$20
Most laboratory tests	$10	$20
Most X-rays and diagnostic testing	$10	$30
Outpatient surgery per procedure	$100	$125
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$5 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$25 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$20 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	10% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$200 per day (up to overall out-of-pocket maximum)	$250 per day up to 5 days per admission, then no charge
OTHER Certain durable medical equipment (DME)	20% (base coverage, plus supplemental coverage up to $2,000 per year)	10% (base coverage, plus supplemental coverage up to $2,000 per year combined)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Covered[1]	Not covered[2]
Adult optical (eyewear)	$150 allowance (every 24 months)	Not covered
Pediatric optical (eyewear)	$150 allowance (every 24 months)	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Benefits payable for diagnosis and treatment of infertility and fertility services will be covered at the same cost-sharing as base medical service. Invitro fertilization is covered.

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$20 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$20 Copayment HMO	Platinum 90 HMO 0/20 PCP + Child Dental*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$2,500/$5,000	$4,500/$9,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$20	$20
Specialty office visits	$20	$30
Urgent care visits	$20	$20
Most laboratory tests	$10	$20
Most X-rays and diagnostic testing	$10	$30
Outpatient surgery per procedure	$150	$125
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$5 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$20 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	10% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$300 per day (up to overall out-of-pocket maximum)	$250 per day (up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	20% (base coverage, plus supplemental coverage up to $2,000 per year)	10% (base coverage, plus supplemental coverage up to $2,000 per year combined)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Not covered[1]	Not covered[1]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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

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$30 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$30 Copayment HMO	Gold 80 HMO 0/40 PCP + Child Dental Alt*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$3,000/$6,000	$8,500/$17,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30	$40
Specialty office visits	$30	$60
Urgent care visits	$30	$40
Most laboratory tests	$10	$30
Most X-rays and diagnostic testing	$10	$40
Outpatient surgery per procedure	$200	$400
PRESCRIPTIONS Generic drugs	$10 (up to a 100-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$35 (after pharmacy deductible; up to a 100-day supply; does not apply to out-of-pocket maximum)	$50 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$400 per day (up to overall out-of-pocket maximum)	$600 per day (up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	50% (base coverage only)	20% (base coverage, plus supplemental coverage up to $2,000 per year combined)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Not covered[1]	Not covered[1]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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

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$50 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$50 Copayment HMO	Gold 80 HMO 0/40 PCP + Child Dental Alt*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$0	$0
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000	$8,500/$17,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$50	$40
Specialty office visits	$50	$60
Urgent care visits	$50	$40
Most laboratory tests	$10	$30
Most X-rays and diagnostic testing	$10	$40
Outpatient surgery per procedure	$250	$320
PRESCRIPTIONS Generic drugs	$10 (up to a 100-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$35 (after pharmacy deductible; up to a 100-day supply; does not apply to out-of-pocket maximum)	$50 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per day (up to overall out-of-pocket maximum)	$600 per day (up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	50% (base coverage only)	20% (base coverage, plus supplemental coverage up to $2,000 per year combined)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Not covered[1]	Not covered[1]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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

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$30/$1,000 DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$1,000 Deductible HMO	Gold 80 HMO 1000/40 PCP + Child Dental Alt*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$1,000/$2,000 (embedded)	$1,000/$2,000 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000 (embedded)	$8,200 / $16,400 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30	$40
Specialty office visits	$30	$60
Urgent care visits	$50	$40
Most laboratory tests	$10 (after deductible)	$30
Most X-rays and diagnostic testing	$10 (after deductible)	$60
Outpatient surgery per procedure	$250 (after deductible)	$350 (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$50 after $250/$500 drug deductible (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum after $250/$500 drug deductible (up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies,therapies, birth services	$500 per day (after deductible; up to overall out-of-pocket maximum)	$600 per day (after plan deductible; up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)	20% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Not covered[1]	Not covered[1]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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$30/$1,500 DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$1,500 Deductible HMO	Silver 70 HMO 2000/65 PCP + Child Dental Alt*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$1,500/$3,000 (embedded)	$2,000/$4,000 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000 (embedded)	$8,900/$17,800 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30	$65
Specialty office visits	$30	$100
Urgent care visits	$30	$65
Most laboratory tests	$10 (after deductible)	$35
Most X-rays and diagnostic testing	$10 (after deductible)	$75 (after plan deductible)
Outpatient surgery per procedure	$250 (after deductible)	45% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$20 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$100 (up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after plan deductible) (up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$500 per day (after deductible; up to overall out-of-pocket maximum)	45% (after plan deductible; up to 5 days per admission, then no charge)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)	45% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Not covered[1]	Not covered[1]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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$40/$2,000 DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$40/$2,000 Deductible HMO	Silver 70 HMO 2300/65 PCP + Child Dental Alt*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$2,000/$4,000 (embedded)	$2,300/$4,600 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$4,500/$9,000 (embedded)	$9,100/$18,200 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$40	$65
Specialty office visits	$40	$100
Urgent care visits	$40	$65
Most laboratory tests	$10 (after deductible)	$45
Most X-rays and diagnostic testing	$10 (after deductible)	$80 (after plan deductible)
Outpatient surgery per procedure	30% (after deductible)	45% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$20 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$35 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$100 (after $500/$1000 drug deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after $500/$1000 drug deductible; up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% per admission (after deductible; up to overall out-of-pocket maximum)	45% per admission (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)	45% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Not covered[1]	Not covered[1]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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$0/$2,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$0/$2,000 HSA-Qualified Deductible HMO	Gold 80 HDHP 1900/15% PCP + Child Dental ALT*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$2,000/$4,000 (aggregate)	Self-only – $1,900 Individual – $3,400 Family – $3,800 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000 (aggregate)	Individual – $4,500 Family – $9,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$0 (after deductible)	15% (after plan deductible)
Specialty office visits	$0 (after deductible)	15% (after plan deductible)
Urgent care visits	$0 (after deductible)	15% (after plan deductible)
Most laboratory tests	$0 (after deductible)	15% (after plan deductible)
Most X-rays and diagnostic testing	$0 (after deductible)	15% (after plan deductible)
Outpatient surgery per procedure	$150 (after deductible)	15% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	$15 (after plan deductible; up to a 30-day supply)
Brand-name drugs	$30 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	45% (after plan deductible; up to a 30-day supply)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	15% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$300 per day (after deductible; up to overall out-of-pocket maximum)	15% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	$0 (after deductible; base coverage only)	15% (after plan deductible; base coverage, plus supplemental coverage up to $2,000 per year combined)
Certain prosthetic and orthotic devices	$0 (after deductible)	$0 (after plan deductible)
Fertility	Not covered[1]	Not covered[1]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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$0/$3,400 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$0/$3,400 HSA-Qualified Deductible HMO	Silver 70 HDHP HMO 3200/25% PCP + Child Dental*
	MEMBER PAYS	MEMBER PAYS
ANNUAL PLAN DEDUCTIBLE Individual/Family	$3,400/$6,600 (embedded)	Self-only – $3,200 Individual – $3,400 Family – $6,400 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$4,500/$9,000 (embedded)	Individual – $8,300 Family – $16,600 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$0 (after deductible)	25% (after plan deductible)
Specialty office visits	$0 (after deductible)	25% (after plan deductible)
Urgent care visits	$0 (after deductible)	25% (after plan deductible)
Most laboratory tests	$0 (after deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	$0 (after deductible)	25% (after plan deductible)
Outpatient surgery per procedure	$250 (after deductible)	25% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	25% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	25% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	25% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$450 per day (after deductible; up to overall out-of-pocket maximum)	25% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	$0 (after deductible; base coverage only)	25% (after plan deductible; base coverage, plus supplemental coverage up to $2,000 per year combined)
Certain prosthetic and orthotic devices	$0 (after deductible)	$0 (after plan deductible)
Fertility	Not covered[1]	Not covered[1]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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

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$30/$3,400 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$3,400 HSA-Qualified Deductible HMO	Silver 70 HDHP HMO 3200/25% PCP + Child Dental*
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$3,400/$6,600 (embedded)	Self-only – $3,200 Individual – $3,400 Family – $6,400 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$5,950/$11,900 (embedded)	Individual – $8,300 Family – $16,600 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30 (after deductible)	25% (after plan deductible)
Specialty office visits	$30 (after deductible)	25% (after plan deductible)
Urgent care visits	$30 (after deductible)	25% (after plan deductible)
Most laboratory tests	$10 (after deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	$10 (after deductible)	25% (after plan deductible)
Outpatient surgery per procedure	30% (after deductible)	25% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	25% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (after deductible; up to a 30-day supply; applies to out-of-pocket maximum)	25% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	25% per prescription up to $250 maximum (after plan deductible; up to a 30-day supply; applies to out-of-pocket maximum)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% per admission (after deductible; up to overall out-of-pocket maximum)	25% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	20% (after deductible; base coverage only)	25% (after plan deductible; base coverage, plus supplemental coverage up to $2,000 per year combined)
Certain prosthetic and orthotic devices	$0 (after deductible)	$0 (after plan deductible)
Fertility	Not covered[1]	Not covered[1]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

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

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$30/$1,500 DEDUCTIBLE HMO PLAN WITH HRA

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$1,500 Deductible HMO with HRA	Gold 80 HRA HMO 2250/35 PCP[1] + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$1,500/$3,000 (embedded)	$2,250/$4,500 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$3,500/$7,000 (embedded)	$8,500/$17,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30 (after deductible)	$35
Specialty office visits	$30 (after deductible)	$50
Urgent care visits	$30 (after deductible)	$35
Most laboratory tests	$10 (after deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	$10 (after deductible)	25% (after plan deductible)
Outpatient surgery per procedure	20% (after deductible)	25% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$30 (after $100/ $200 drug deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after $100 drug deductible; up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% per admission (after deductible; up to overall out-of-pocket maximum)	25% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)	50% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Not covered[2]	Not covered[2]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Groups selecting the Gold 80 HRA HMO 2250/35 PCP + Child Dental plan must establish and fund an HRA for each enrolled employee. The allowable funding options are $200 or $400 per employee and $400 or $800 respectively per family, if the group covers dependents.

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

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$30/$2,500 DEDUCTIBLE HMO PLAN WITH HRA

FEATURES	Grandfathered (nonmetal)	Metal
	$30/$2,500 Deductible HMO with HRA	Gold 80 HRA HMO 2250/35 PCP[1] + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	$2,500/$5,000 (embedded)	$2,250/$4,500 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	$5,000/$10,000 (embedded)	$8,500/$17,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	$30 (after deductible)	$35
Specialty office visits	$30 (after deductible)	$50
Urgent care visits	$30 (after deductible)	$35
Most laboratory tests	$10 (after deductible)	25% (after plan deductible)
Most X-rays and diagnostic testing	$10 (after deductible)	25% (after plan deductible)
Outpatient surgery per procedure	20% (after deductible)	25% (after plan deductible)
PRESCRIPTIONS Generic drugs	$10 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$15 (up to a 30-day supply; applies to out-of-pocket maximum)
Brand-name drugs	$30 (up to a 30-day supply; does not apply to out-of-pocket maximum)	$30 (after $100/$200 drug deductible; up to a 30-day supply; applies to out-of-pocket maximum)
Specialty drugs	For most nonmetal plans, outpatient specialty drugs are included in the brand-name drug category and are subject to a fixed copayment.	20% per prescription up to $250 maximum (after $100 drug deductible; up to a 30-day supply)
HOSPITAL INPATIENT CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	20% per admission (after deductible; up to overall out-of-pocket maximum)	25% (after plan deductible; up to overall out-of-pocket maximum)
OTHER Certain durable medical equipment (DME)	30% (base coverage only)	50% (base coverage, plus supplemental coverage up to $2,000 per year after plan deductible)
Certain prosthetic and orthotic devices	$0	$0
Fertility	Not covered[2]	Not covered[2]
Adult optical (eyewear)	Not covered	Not covered
Pediatric optical (eyewear)	Not covered	1 pair of eyeglasses or contact lenses per year
Pediatric dental	Not covered	Covered

[1]Groups selecting the Gold 80 HRA HMO 2250/35 PCP + Child Dental plan must establish and fund an HRA for each enrolled employee. The allowable funding options are $200 or $400 per employee and $400 or $800 respectively per family, if the group covers dependents.

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

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NOTES

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