

Silver 70 HDHP HMO 3200/25% PCP + Child Dental*

For effective dates January 1 - December 1, 2026

Principal benefits for Kaiser Permanente for Small Business

“Kaiser Permanente for Small Business” is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the *EOC*.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	\$8,300 ¹	\$8,300 ¹	\$16,600 ¹
Plan Deductible	\$3,200 ¹	\$3,400 ¹	\$6,400 ¹
Drug Deductible	Not applicable	Not applicable	Not applicable

Plan Provider Office Visits

Most Primary Care Visits and most Non-Physician Specialist Visits
 Most Physician Specialist Visits.....
 Routine physical maintenance exams, including well-woman exams....
 Well-child preventive exams (through age 23 months)
 Routine eye exams with a Plan Optometrist.....
 Urgent care consultations, evaluations, and treatment
 Most physical, occupational, and speech therapy

You Pay

25% Coinsurance after Plan Deductible
 25% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)
 25% Coinsurance after Plan Deductible
 25% Coinsurance after Plan Deductible

Telehealth Visits

Primary Care Visits and Non-Physician Specialist Visits by interactive
 video or telephone
 Physician Specialist Visits by interactive video or telephone

You Pay

No charge after Plan Deductible
 No charge after Plan Deductible

Outpatient Services

Outpatient surgery and certain other outpatient procedures
 Most immunizations (including the vaccine).....
 Most X-rays and laboratory tests
 Preventive X-rays, screenings, and laboratory tests as described in
 the *EOC*.....

You Pay

25% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)
 25% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)

Hospital Inpatient Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and
 drugs.....

You Pay

25% Coinsurance after Plan Deductible

Emergency Services

Emergency department visits

You Pay

25% Coinsurance after Plan Deductible

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see “Hospital Inpatient Services” for inpatient Cost Share)

Ambulance Services

Ambulance Services

You Pay

25% Coinsurance after Plan Deductible

Prescription Drug Coverage

Covered outpatient items in accord with our drug formulary guidelines:
 Most generic items (Tier 1) at a Plan Pharmacy or through our mail-
 order service
 Most brand-name items (Tier 2) at a Plan Pharmacy or through our
 mail-order service
 Most specialty items (Tier 4) at a Plan Pharmacy

You Pay

25% Coinsurance (not to exceed \$250) for up to a
 30-day supply after Plan Deductible
 25% Coinsurance (not to exceed \$250) for up to a
 30-day supply after Plan Deductible
 25% Coinsurance (not to exceed \$250) for up to a
 30-day supply after Plan Deductible

Durable Medical Equipment (DME)	You Pay
Base DME items as described in the <i>EOC</i>	25% Coinsurance after Plan Deductible
Supplemental DME items up to a \$2,000 benefit limit per Accumulation Period as described in the <i>EOC</i>	25% Coinsurance after Plan Deductible
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	25% Coinsurance after Plan Deductible
Outpatient mental health evaluation and treatment.....	No charge after Plan Deductible
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	25% Coinsurance after Plan Deductible
Outpatient substance use disorder evaluation and treatment.....	No charge after Plan Deductible
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	25% Coinsurance after Plan Deductible
Other	You Pay
Eyeglasses or contact lenses for Pediatric Members:	
One complete pair of eyeglasses (frames and lenses) or one pair of contact lenses per Accumulation Period, as described in the <i>EOC</i> ...	No charge (Plan Deductible doesn't apply)
Skilled nursing facility care (up to 100 days per benefit period).....	25% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge after Plan Deductible
Chiropractic and acupuncture.....	25% per visit after deductible for physician-referred acupuncture only
Pediatric vision exam.....	No charge
Adult optical (eyewear).....	Not covered ²

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

1. This plan has an embedded deductible and annual 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.

2. 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.

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

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