Product	Plan	Plan Deductible (Individual/Family)	Out-of-Pocket Maximum (Individual/Family)	Primary Care Office Visit	Specialist Office Visit	Hospital Inpatient Care	Prescription Drugs (up to a 30-day supply) (Generic (Tier1)/Brand (Tier 2)/ Specialty (Tier 4))	Available in Covered California for Small Business and CaliforniaChoice®
Copay HMO plans	Platinum 90 HMO 0/10 + Child Dental Alt†	$0/$0	$3,000[1,3]/$6,000[1,3]	$10	$20	$500 per admission	$5[4,5] $15[4,5] 10% per prescription up to $250 maximum[4,5]	Yes
	Platinum 90 HMO 0/20 + Child Dental	$0/$0	$4,500[1,3]/$9,000[1,3]	$20	$30	$250/day up to 5 days per admission[6]	$5[4,5] $20[4,5] 10% per prescription up to $250 maximum[4,5]	Yes
	Gold 80 HMO 0/35 + Child Dental Alt†	$0/$0	$7,700[1,3]/$15,400[1,3]	$35	$60	$600/day up to 5 days per admission[6]	$15[4,5] $50[4,5] 20% per prescription up to $250 maximum[4,5]	Yes
Deductible HMO plans	Platinum 90 HMO 250/30 + Child Dental Alt†	$250/$500	$3,000[2,3]/$6,000[2,3]	$30	$50	$500 per admission (after plan deductible)	$10[4,5] $20[4,5] 10% per prescription up to $250 maximum (after plan deductible)[4,5]	Yes
	Gold 80 HMO 250/35 + Child Dental	$250[2]/$500[2]	$7,800[2,3]/$15,600[2,3]	$35	$55	$600/day up to 5 days per admission (after plan deductible)[6]	$15[4,5] $40[4,5] 20% per prescription up to $250 maximum[4,5]	Yes
	Gold 80 HMO 1000/40 + Child Dental Alt†	$1,000[2]/$2,000[2]	$7,800[2,3]/$15,600[2,3]	$40	$60	$600/day up to 5 days per admission (after plan deductible)[6]	$20[4,5] $50 (after $250/$500 drug deductible)[4,5,10] 20% per prescription up to $250 maximum (after $250/$500 drug deductible)[4,5,10]	Yes
	Silver 70 HMO 1900/65 + Child Dental Alt†	$1,900[2]/$3,800[2]	$8,750[2,3]/$17,500[2,3]	$65	$100	45% (after plan deductible)	$20[4,5] $100[4,5] 20% per prescription up to $250 maximum (after plan deductible)[4,5]	Yes
	Silver 70 HMO 2300/65 + Child Dental Alt†	$2,300[2]/$4,600[2]	$8,750[2,3]/$17,500[2,3]	$65	$100	45% (after plan deductible)	$20[4,5] $100 (after $500/$1,000 drug deductible)[4,512] 20% per prescription up to $250 maximum (after $500/$1,000 drug deductible)[4,5,12]	Yes
	Silver 70 HMO 2500/55 + Child Dental	$2,500[2]/$5,000[2]	$8,750[2,3]/$17,500[2,3]	$55	$90	35% (after plan deductible)	$19[4,5] $85 (after $300/$600 drug deductible)[4,5,11] 30% per prescription up to $250 maximum (after $300/$600 drug deductible)[4,5,11]	Yes
	Silver 70 HMO 2950/65 +Child Dental Alt†	$2,950[2]/$5,900[2]	$9,100[2,3]/$18,200[2,3]	$65	$100	45% (after plan deductible)	$20[4,5] $100 (after plan deductible)[4,5] 45% per prescription up to $250 maximum (after plan deductible)[4,5]	Yes
	Bronze 60 HMO 5400/60 + Child Dental Alt†	$5,400[2]/$10,800[2]	$8,600[2,3]/$17,200[2,3]	$60 (after plan deductible)[13]	$80 (after plan deductible)[13]	50% (after plan deductible)	$20[4,5] 50% per prescription up to $500 maximum (after plan deductible)[4,5] 50% per prescription up to $500 maximum (after plan deductible)[4,5]	Yes
	Bronze 60 HMO 6300/60 + Child Dental	$6,300[2]/$12,600[2]	$9,100[2,3]/$18,200[2,3]	$60 (after plan deductible)[13]	$95 (after plan deductible)[13]	40% (after plan deductible)	$17 (after $500/$1,000 drug deductible)[4,12] 40% per prescription up to $500 maximum (after $500/$1,000 drug deductible)[4,12] 40% per prescription up to $500/$1,000 maximum (after $500 drug deductible)[4,12]	Yes

This is only a summary. It doesn't fully describe benefit coverage for every plan. For complete coverage details, including exclusions, limitations, and plan terms, contact a Kaiser Permanente representative or refer to your service agreement.

(continues)

Product	Plan	Plan Deductible (Individual/Family)	Out-of-Pocket Maximum (Individual/Family)	Primary Care Office Visit	Specialist Office Visit	Hospital Inpatient Care	Prescription Drugs (up to a 30-day supply) (Generic/Brand/Specialty)	Available in Covered California for Small Business and CaliforniaChoice®
HSA-qualified High Deductible Health Plans (HSA can be administered through Kaiser Permanente)	Gold 80 HDHP HMO 1750/15% + Child Dental Alt[1]	Self only-$1,750[2,7] Individual-$3,200[2,7] Family-$3,500[2,7]	$3,700[2,3]/$7,400[2,3]	15% (after plan deductible)	15% (after plan deductible)	15% (after plan deductible)	$15 (after plan deductible)[4,5] $45 (after plan deductible)[4,5] 15% per prescription up to $250 maximum (after plan deductible)[4,5]	Yes
	Silver 70 HDHP HMO 2850/25% + Child Dental	Self/Individual/Family $2,850[2,7]/$3,200[2,7]/$5,700[2,7]	$7,500[2,3]/$15,000[2,3]	25% (after plan deductible)	25% (after plan deductible)	25% (after plan deductible)	25% per prescription up to $250 maximum (after plan deductible)[4]	Yes
	Bronze 60 HDHP HMO 7050/0% + Child Dental	$7,050[2]/$14,100[2]	$7,050[2,3]/$14,100[2,3]	0% (after plan deductible)	0% (after plan deductible)	0% (after plan deductible)	0% (after plan deductible)[4,5]	Yes
Deductible HMO with Health Reimbursement Arrangement plan[8]	Gold 80 HRA HMO 2250/35 + Child Dental	$2,250[2]/$4,500[2]	$8,500[2,3]/$17,000[2,3]	$35	$50	25% (after plan deductible)	$15[4,5] $30 (after $100/$200 drug deductible)[4,5,9] 20% per prescription up to $250 maximum (after $100/$200 drug deductible)[4,5,9]	No
PPO plans[14,17]	Platinum 90 PPO 0/15 + Child Dental	**In-network:** $0[2] **Out-of-network:** $500[2]/$1,000[2]	**In-network:** $4,500[18]/$9,000[18] **Out-of-network:** $9,000[2,18]/$18,000[2,18]	**In-network:** $15 **Out-of-network:** 30% (after plan deductible)	**In-network:** $30 **Out-of-network:** 30% (after plan deductible)	**In-network:** 10% **Out-of-network:** 30% (after plan deductible)	**In-network:** $10[5,15,16] $25[5,15,16] 10% per prescription up to $250 maximum[5,15,16] **Out-of-network:** Not Covered	No
	Gold 80 PPO 350/25 + Child Dental	**In-network:** $350[2]/$700[2] **Out-of-network:** $1,000[2]/$2,000[2]	**In-network:** $7,800[18]/$15,600[18] **Out-of-network:** $15,600[2,18]/$31,200[2,18]	**In-network:** $25 **Out-of-network:** 40% (after plan deductible)	**In-network:** $50 **Out-of-network:** 40% (after plan deductible)	**In-network:** 20% (after plan deductible) **Out-of-network:** 40% (after plan deductible)	**In-network:** $15[5,15,16] $50[5,15,16] 20% per prescription up to $250 maximum[5,15,16] **Out-of-network:** Not Covered	No
	Silver 70 PPO 2500/55 + Child Dental	**In-network:** $2,500[2]/$5,000[2] **Out-of-network:** $5,000[2]/$10,000[2]	**In-network:** $8,750[2,18]/$17,500[2,18] **Out-of-network:** $17,500[2,18]/$35,000[2,18]	**In-network:** $55 **Out-of-network:** 40% (after plan deductible)	**In-network:** $90 **Out-of-network:** 40% (after plan deductible)	**In-network:** 35% (after plan deductible) **Out-of-network:** 50% (after plan deductible)	**In-network:** $19[5,11,15,16] $85 (after $300/$600 drug deductible)[5,11,15,16] 30% per prescription up to $250 maximum (after $300/$600 drug deductible)[5,11,15,16] **Out-of-network:** Not Covered	No
	Bronze 60 PPO 6300/65 + Child Dental	**In-network:** $6,300[2]/$12,600[2] **Out-of-network:** $12,600[2]/$25,200[2]	**In-network:** $9,100[2,18]/$18,200[2,18] **Out-of-network:** $18,200[2,18]/$36,400[2,18]	**In-network:** $60 (deductible applies after 1st 3 non-preventive visits)[13] **Out-of-network:** 100% up to out-of-pocket maximum[19]	**In-network:** $95 (deductible applies after 1st 3 non-preventive visits)[13] **Out-of-network:** 100% up to out-of-pocket maximum[19]	**In-network:** 40% (after plan deductible) **Out-of-network:** 100% up to out-of-pocket maximum[19]	**In-network:** $17 (after $500/$1,000 drug deductible)[5,12,15,16] 40% per prescription up to $500 maximum (after $500/$1,000 drug deductible)[5,12,15,16] 40% per prescription up to $500 maximum (after $500/$1,000 drug deductible)[5,12,15,16] **Out-of-network:** Not Covered	No

†The abbreviation "ALT," in certain plan names, designates Kaiser Permanente developed plans that are different from the standard plans and are available through Covered California for Small Business.

1. 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. **2.** 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. **3.** Out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a year. **4.** 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. **5.** Mail order: Up to a 100-day supply of qualified prescriptions for the cost of a 60-day supply. **6.** After the 5 days, additional days for the same admission are covered at no charge. **7.** 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. **8.** 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 $100 to $400 per employee. If the group covers dependents, the allowable funding range per family is $200 to $800. **9.** This plan has a drug deductible of $100 per individual and $200 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible 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. **10.** This plan has a drug deductible of $250 per individual and $500 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible 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.** This plan has a drug deductible of $300 per individual and $600 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible 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. **12.** This plan has a drug deductible of $500 per individual and $1,000 for family for prescription costs and out-of-pocket maximum. Each family member will begin paying copays or coinsurance after meeting his or her individual drug deductible or out-of-pocket maximum (depending on the benefit), or when the family deductible 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. **13.** 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. **14.** The Kaiser Permanente PPO Plan is underwritten by Kaiser Permanente Insurance (KPIC), a subsidiary of kaiser Foundation Health Plan, Inc. **15.** 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. **16.** 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. **17.** 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. **18.** 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. **19.** 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.