
Plan comparison guide

Kaiser Permanente for small businesses ■ For effective dates January 1-December 1, 2023

Use this 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 **800-790-4661, option 3**, to speak with our Small Business Services, Customer Service Account Management Team.

This is a comparison 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*.

Refer to the *Plan Highlights* brochure online at kp.org/smallbusinessplans/ca for more information and restrictions.

\$5 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	\$5 Copayment HMO	Platinum 90 HMO 0/10* + 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) ¹
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	50% (IVF not covered)	Not covered
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

¹Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

Refer to the *Plan Highlights* brochure online at kp.org/smallbusinessplans/ca for more information and restrictions.

\$15 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	\$15 Copayment HMO	Platinum 90 HMO 0/20* + 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) ¹
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	50% (IVF not covered)	Not covered
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

¹Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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\$20 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	\$20 Copayment HMO	Platinum 90 HMO 0/20* + 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) ¹
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	Not covered	Not covered
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

¹Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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\$30 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	\$30 Copayment HMO	Gold 80 HMO 0/30* + Child Dental Alt
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	\$0	\$0
OUT-OF-POCKET MAXIMUM Individual/Family	\$3,000/\$6,000	\$7,500/\$15,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	\$30	\$30
Specialty office visits	\$30	\$50
Urgent care visits	\$30	\$30
Most laboratory tests	\$10	\$30
Most X-rays and diagnostic testing	\$10	\$40
Outpatient surgery per procedure	\$200	\$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	\$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) ¹	20% (base coverage, plus supplemental coverage up to \$2,000 per year combined) ¹
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	Not covered	Not covered
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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\$50 COPAY HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	\$50 Copayment HMO	Gold 80 HMO 0/30* + Child Dental Alt
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	\$0	\$0
OUT-OF-POCKET MAXIMUM Individual/Family	\$3,500/\$7,000	\$7,500/\$15,000 (embedded)
IN THE MEDICAL OFFICE Primary care visits	\$50	\$30
Specialty office visits	\$50	\$50
Urgent care visits	\$50	\$30
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) ¹	20% (base coverage, plus supplemental coverage up to \$2,000 per year combined) ¹
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	Not covered	Not covered
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

¹Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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\$30/\$1,000 DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	\$30/\$1,000 Deductible HMO	Gold 80 HMO 1000/40* + 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)	\$7,800/\$15,600 (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
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)	\$50 after \$250 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 (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) ¹	20% (base coverage, plus supplemental coverage up to \$2,000 per year after plan deductible) ¹
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	Not covered	Not covered
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

¹Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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\$30/\$1,500 DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	\$30/\$1,500 Deductible HMO	Silver 70 HMO 1900/65* + Child Dental Alt
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	\$1,500/\$3,000 (embedded)	\$1,900/\$3,800 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	\$3,500/\$7,000 (embedded)	\$8,750/\$17,500 (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)	\$30
Most X-rays and diagnostic testing	\$10 (after deductible)	\$75
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) ¹	45% (base coverage, plus supplemental coverage up to \$2,000 per year after plan deductible) ¹
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	Not covered	Not covered
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* + 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)	\$8,750/\$17,500 (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)	\$30
Most X-rays and diagnostic testing	\$10 (after deductible)	\$75
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 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 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) ¹	45% (base coverage, plus supplemental coverage up to \$2,000 per year after plan deductible) ¹
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	Not covered	Not covered
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

¹Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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

FEATURES	Grandfathered (nonmetal)	Metal
	\$0/\$2,000 HSA-Qualified Deductible HMO	Silver 70 HDHP HMO 2700/25%* + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	\$2,000/\$4,000 (aggregate)	Self-only – \$2,700 Individual – \$3,000 Family – \$5,400 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	\$3,500/\$7,000 (aggregate)	Individual – \$7,200 Family – \$14,400 (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	\$150 (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	\$300 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) ¹	25% (after plan deductible; base coverage, plus supplemental coverage up to \$2,000 per year combined) ¹
Certain prosthetic and orthotic devices	\$0 (after deductible)	\$0 (after plan deductible)
Fertility	Not covered	Not covered
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/\$3,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	\$0/\$3,000 HSA-Qualified Deductible HMO	Silver 70 HDHP HMO 2700/25%* + Child Dental
	MEMBER PAYS	MEMBER PAYS
ANNUAL PLAN DEDUCTIBLE Individual/Family	\$3,000/\$6,000 (embedded)	Self-only – \$2,700 Individual – \$3,000 Family – \$5,400 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	\$4,500/\$9,000 (embedded)	Individual – \$7,200 Family – \$14,400 (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) ¹	25% (after plan deductible; base coverage, plus supplemental coverage up to \$2,000 per year combined) ¹
Certain prosthetic and orthotic devices	\$0 (after deductible)	\$0 (after plan deductible)
Fertility	Not covered	Not covered
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

¹Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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\$30/\$3,000 HSA-QUALIFIED DEDUCTIBLE HMO PLAN

FEATURES	Grandfathered (nonmetal)	Metal
	\$30/\$3,000 HSA-Qualified Deductible HMO	Silver 70 HDHP HMO 2700/25%* + Child Dental
	MEMBER PAYS	MEMBER PAYS
PLAN DEDUCTIBLE Individual/Family	\$3,000/\$6,000 (embedded)	Self-only – \$2,700 Individual – \$3,000 Family – \$5,400 (embedded)
OUT-OF-POCKET MAXIMUM Individual/Family	\$5,950/\$11,900 (embedded)	Individual – \$7,200 Family – \$14,400 (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) ¹	25% (after plan deductible; base coverage, plus supplemental coverage up to \$2,000 per year combined) ¹
Certain prosthetic and orthotic devices	\$0 (after deductible)	\$0 (after plan deductible)
Fertility	Not covered	Not covered
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

¹Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

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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 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 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) ²	50% (base coverage, plus supplemental coverage up to \$2,000 per year after plan deductible) ²
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	Not covered	Not covered
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

¹Groups selecting the Gold HRA 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.

²Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

Refer to the *Plan Highlights* brochure online at kp.org/smallbusinessplans/ca for more information and restrictions.

\$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 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 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) ²	50% (base coverage, plus supplemental coverage up to \$2,000 per year after plan deductible) ²
Certain prosthetic and orthotic devices	\$0	\$0
Fertility	Not covered	Not covered
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

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

²Please refer to your *Evidence of Coverage* for information on what's included in coverage for DME.

NOTES

