

Gold 80 HMO 250/35 PCP* + Child Dental

For effective dates January 1 - December 1, 2025

Principal benefits for Kaiser Permanente for Small Business

Accumulation Period

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

Out-of-Pocket Maximums and Deductibles

Amounts Per Accumulation Period

Plan Out-of-Pocket Maximum

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.

Self-Only Coverage

(a Family of one Member)

\$7,800¹

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. Family Coverage

Family Coverage

Each Member in a Family

of two or more Members

\$7,8001

Entire Family of two or

more Members

\$15,600¹

I lan Out-of-I ocket waximum	Ψ1,000	ΨI ,000	Ψ13,000	
Plan Deductible	\$250 ¹	\$250 ¹	\$500 ¹	
Drug Deductible	None	None	None	
Plan Provider Office Visits		You Pay	You Pay	
Most Primary Care Visits and most Non-Physician Specialist Visits Most Physician Specialist Visits		\$55 per visit (Plan Dedu 5 No charge (Plan Deduc No charge (Plan Deduc No charge (Plan Deduc \$35 per visit (Plan Deduc \$35 per visit (Plan Deduc	 \$55 per visit (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) \$35 per visit (Plan Deductible doesn't apply) \$35 per visit (Plan Deductible doesn't apply) 	
Telehealth Visits			You Pay	
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone		No charge (Plan Deduc No charge (Plan Deduc	No charge (Plan Deductible doesn't apply)	
Outpatient Services			You Pay	
Outpatient surgery and certain other outpatient procedures Most immunizations (including the vaccine) Most X-rays Most laboratory tests Preventive X-rays, screenings, and laboratory tests as described in		No charge (Plan Deduc \$55 per encounter (Plan \$35 per encounter (Plan	No charge (Plan Deductible doesn't apply) \$55 per encounter (Plan Deductible doesn't apply) \$35 per encounter (Plan Deductible doesn't apply)	
the EOCMRI, most CT, and PET scans				
Hospital Inpatient Services		You Pay		
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs				
Emergency Services		You Pay	You Pay	
Emergency department visits				
Ambulance Services		You Pay	D. L. et I	
Ambulance Services			Deductible	
Prescription Drug Coverage		You Pay		
Covered outpatient items in accord with Most generic items (Tier 1) at a Plan	Pharmacy	\$15 for up to a 30-day s doesn't apply)		
Most generic (Tier 1) refills through o	ur mail-order service	\$30 for up to a 100-day doesn't apply)	supply (Plan Deductible	
Most brand-name items (Tier 2) at a	Plan Pharmacy		supply (Plan Deductible	

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(continues)



Prescription Drug Coverage	You Pay	
Most brand-name (Tier 2) refills through our mail-order service	\$80 for up to a 100-day supply (Plan Deductible doesn't apply)	
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed \$250) for up to a 30-day supply (Plan Deductible doesn't apply)	
Durable Medical Equipment (DME)	You Pay	
Base DME items as described in the EOC	20% Coinsurance (Plan Deductible doesn't apply)	
Supplemental DME items up to a \$2,000 benefit limit per		
Accumulation Period as described in the EOC		
Mental Health Services	You Pay	
Inpatient psychiatric hospitalization	\$600 per day up to a maximum of \$3,000 per admission after Plan Deductible	
Individual outpatient mental health evaluation and treatment		
Group outpatient mental health treatment	\$17 per visit (Plan Deductible doesn't apply)	
Substance Use Disorder Treatment	You Pay	
Inpatient detoxification		
	admission after Plan Deductible	
Individual outpatient substance use disorder evaluation and treatment		
Group outpatient substance use disorder treatment		
Home Health Services	You Pay	
Home health care (up to 100 visits per Accumulation Period)	\$30 per visit (Plan Deductible doesn't apply)	
Other	You Pay	
Eyeglasses or contact lenses for Pediatric Members:		
One complete pair of eyeglasses (frames and lenses) or one pair of	N	
contact lenses per Accumulation Period, as described in the EOC	No charge (Plan Deductible doesn't apply)	
Skilled nursing facility care (up to 100 days per benefit period)	\$300 per day up to a maximum of \$1,500 per admission after Plan Deductible	
Prosthetic and orthotic devices as described in the EOC		
Diagnosis and treatment of infertility and artificial insemination	0 (
Assisted reproductive technology ("ART") Services	Not covered	
Chiropractic and acupuncture	\$35 per visit for physician-referred acupuncture	
	only	
Pediatric vision exam	No charge (under age 19; one pair of eyeglasses	
Adult antical (avaivable)	from a limited selection)	
Adult optical (eyewear)	Not covered ³	

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

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.

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

^{3.} 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.