KAISER PERMANENTE®

Bronze 60 HMO 5800/60 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

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	$8,850[1]	$8,850[1]	$17,700[1]
Plan Deductible	$5,800[1]	$5,800[1]	$11,600[1]
Drug Deductible	$450	$450	$900

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$60 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$95 per visit after Plan Deductible*
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$60 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$60 per visit (Plan Deductible doesn't apply)

*The Plan Deductible doesn't apply to your first three visits for specialty care as described in the *EOC*.

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	40% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays	40% Coinsurance after Plan Deductible
Most laboratory tests	$40 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)

Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	40% Coinsurance after Plan Deductible

Emergency Services	**You Pay**
Emergency department visits	40% 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	**You Pay**
Ambulance Services	40% Coinsurance after Plan Deductible

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$19 for up to a 30-day supply (Drug Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service	$38 for up to a 100-day supply (Drug Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	40% Coinsurance (not to exceed $500) for up to a 30-day supply after Drug Deductible

(continues)

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Prescription Drug Coverage	You Pay
Most specialty items (Tier 4) at a Plan Pharmacy	40% Coinsurance (not to exceed $500) for up to a 30-day supply after Drug Deductible
Durable Medical Equipment (DME)	**You Pay**
Base DME items as described in the *EOC*	40% Coinsurance after Plan Deductible
Supplemental DME items up to a $2,000 benefit limit per Accumulation Period as described in the *EOC*	40% Coinsurance after Plan Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	40% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	No charge (Plan Deductible doesn't apply)
Group outpatient mental health treatment	No charge (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	40% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	No charge (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	No charge (Plan Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	40% 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 *EOC*	No charge (Plan Deductible doesn't apply)
Skilled nursing facility care (up to 100 days per benefit period)	40% Coinsurance after Plan Deductible
Base prosthetic and orthotic devices as described in the *EOC*	No charge after Plan Deductible
Supplemental prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination	Not covered[2]
Assisted reproductive technology ("ART") Services	Not covered
Chiropractic and acupuncture	$60 per visit for physician-referred acupuncture only
Pediatric vision exam	No charge (under age 19; one pair of eyeglasses from a limited selection)
Adult optical (eyewear)	Not covered[3]

*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. 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.

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.