PLAN HIGHLIGHTS

For effective dates January 1–December 1, 2014

KAISER PERMANENTE®

Notes for all plans

- Kaiser Permanente plans do not include a pre-existing condition clause. Claims experience will not be taken into consideration.
- The copayment HMO plans, HSA-qualified deductible HMO plans, deductible HMO plans, and the deductible HMO plans with HRA are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the Preferred Provider Organization (PPO) plans as well as the Premier and PPO dental plans. The chiropractic/acupuncture plan is administered by American Specialty Health Plans of California, Inc. The PPO chiropractic/acupuncture plan is administered by Private Healthcare Systems (PHCS).
- All plans cover the essential health benefits, as defined by Affordable Care Act (ACA) regulations, which include pediatric dental services. When employees and dependents enroll in the medical plan(s) you've chosen, we'll also enroll them in a separate pediatric dental plan underwritten by Delta Dental of California. For PPO medical plans, pediatric dental benefits are part of the PPO medical plans coverage and not a separate dental plan.
- This booklet is a summary only. The KFHP *Evidence of Coverage* and the KPIC *Certificate of Insurance* contain a complete explanation of benefits, exclusions, and limitations. The information provided in this brochure is not intended to describe all of the benefits included in each plan, nor is it designed to serve as the *Evidence of Coverage* or *Certificate of Insurance*.
- Summary of Benefits and Coverage (SBC) documents for all of our plans are available at **kp.org/smallbusiness-sbc/ca** to help you make an informed choice about your health plan(s). These documents summarize important information about your health coverage options, so you can easily compare Kaiser Permanente benefits and coverage with those of other carriers.

2014 Small Business Plan Highlights

The health care reform law, known as the Affordable Care Act (ACA), includes changes in health coverage that affect business owners and their employees. From metal tiers to new plan options, navigating the many aspects of ACA can be challenging. But this new market also offers an exciting opportunity for you to reshape your health care strategy and maintain a successful business. As your health care partner, we're here to provide the information you need to help you make the right decisions for your business.

What's inside

Your plan options for 2014

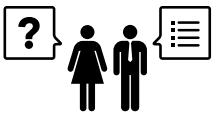
To comply with federal and state regulations, for plan years beginning on or after January 1, 2014, all insurers must offer small group plans that meet new standards for coverage. This excludes grandfathered plans, which are plans that have covered at least one employee and continued unchanged since March 23, 2010.

With ACA, there will be a new way to buy health policies through a health insurance marketplace/exchange set up in each state. Covered California, the agency running California's exchange, supports both small businesses and individuals. There will be a specific program for small businesses called the Small Business Health Options Program, also referred to as the SHOP. Covered California enrollment begins on October 1, 2013, and will offer coverage that takes effect on January 1, 2014. Kaiser Permanente plans are available at every level, so you can purchase coverage directly from us or offer your employees our coverage through Covered California.[1] For more information on Covered California, visit **kp.org/reformforsmallbusiness/ca**.

Essential health benefits

Starting with plan years beginning on or after January 1, 2014, federal and state regulations require nongrandfathered small group commercial plans (with some exceptions, such as retiree and dental-only plans) to cover 10 categories of essential health benefits:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care



Types of plans

All of our plans give your employees what they need to be healthier and more productive every day – top doctors, focus on prevention, innovative health promotion tools, and high-quality, personalized care.

- **Copayment HMO plans** – Predictable copayments and out-of-pocket maximums
- **Deductible HMO plans** – More options at an affordable cost. Monthly payments are lower than traditional HMO plans, so you will be able to reduce premiums.
- **HSA-Qualified Deductible HMO** – Lower premiums plus tax savings[2]
- **Deductible HMO with HRA** – Lower premiums plus tax savings[2]
- **PPO** – Referral-free access to contracted PHCS physicians or any other licensed provider of choice
- **Supplemental coverage** – Dental and chiropractic and acupuncture plans

[1]There are plans available to purchase outside Covered California.
[2]Tax references relate to federal income tax only. Consult with your financial adviser for more information about state income tax laws.

Understanding health plans

In the following "Plan highlights" section, you will get an overview of what your employees can expect to pay for certain services under our plans. There are four main categories of coverage, known as "metal tiers" – bronze, silver, gold, and platinum. These four categories offer different levels of copayments, coinsurance, and deductibles for essential health benefits. For example, the plans under the bronze tier have lower premiums with higher out-of-pocket costs, while other metal-tier plans have higher premiums and lower out-of-pocket costs. Here's a quick look at how you can use the charts to understand the plans.

Here's a quick look at how to use the chart.

	Bronze 5000/60*
FEATURES	Deductible HMO Plan
ANNUAL PLAN DEDUCTIBLE Individual/Family	$5,000/$10,000[10]
PHARMACY ANNUAL DEDUCTIBLE Brand-name drugs	$0
ANNUAL OUT-OF-POCKET MAXIMUM Individual/Family	$6,350/$12,700[1,10]
MAXIMUM BENEFIT WHILE INSURED	Unlimited
IN THE MEDICAL OFFICE Primary care visits	$60 (after deductible)[2]
Urgent care visits	$60 (after deductible)[2]
Specialty office visits	$70 (after deductible)
Preventive exams	$0
Prenatal care	$0[3]
Postpartum care	$0[3]
Well-child preventive care visits	$0[25]
Vaccines (immunizations)	$0
Allergy injections	$5 (after deductible)
Infertility services	Not covered
Occupational, physical, and speech therapy	$60 (after deductible)
Most laboratory tests	30% (after deductible)
Most X-rays and diagnostic	30% (after deductible)
Most MRI/CT/PET scans	30% (after deductible)
Outpatient surgery	30% per procedure (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$300 (after deductible)
Ambulance	$300 (after deductible)
PRESCRIPTIONS Generic drugs	(up to a 30-day supply) $19 (after deductible)[26]
Brand-name drugs	(up to a 30-day supply) $50 (after deductible)[26]
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	30% (after deductible)
MENTAL HEALTH SERVICES In the medical office	$60[2]
In the hospital	30% (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$60[2]
In the hospital (detoxification only)	30% (after deductible)
OTHER Certain durable medical equipment (DME)	30% (after deductible)[6]
Certain prosthetics, orthotics, and devices	$0[6]
Pediatric optical (eyewear)	One pair of frames, lenses, or contact lenses per calendar year[7]
Pediatric vision exam	$0
Adult optical (eyewear)	Not covered[8]
Adult vision exam (for eye refraction)	$0
Home health care (up to 100 visits per calendar year)	$0 (after deductible)
Hospice care	$0 (after deductible)

Please refer to the Footnotes for medical plans on page 8.

Annual plan deductible

The amount employees pay before the plan starts helping them pay for covered services. This is included in the annual out-of-pocket maximum.

Annual out-of-pocket maximum

The most an employee will pay for care during the policy period before the plan starts paying 100 percent for most covered services.

Preventive care at no charge

Most preventive services are covered at no charge, and are not subject to the deductible.

Copayment

This is the set amount employees will pay for certain services, usually after they reach the deductible.

Coinsurance

After reaching the deductible, an employee may start paying a percentage of the total cost for certain services.

Kaiser Permanente Bronze Tier

Plan Highlights

For effective dates 1/1/14–12/1/14

***ALSO AVAILABLE IN COVERED CALIFORNIA**

	Bronze 5000/60*	Bronze HSA 3500/30	Bronze HSA 4500/40%*	Bronze PPO 5000/60 Pending regulatory approval	
FEATURES	Deductible HMO Plan	HSA-Qualified Deductible HMO Plan	HSA-Qualified Deductible HMO Plan	Participating providers (in-network)[9]	Non-participating providers (out-of-network)[9]
ANNUAL PLAN DEDUCTIBLE Individual/Family	$5,000/$10,000[10]	$3,500/$7,000[10]	$4,500/$9,000[28]	$5,000/$10,000[10]	$10,000/$20,000[10]
PHARMACY ANNUAL DEDUCTIBLE Brand-name drugs	$0	$0[30]	$0[30]	$0[30]	
ANNUAL OUT-OF-POCKET MAXIMUM Individual/Family	$6,350/$12,700[1,10]	$6,350/$12,700[1,10]	$6,350/$12,700[1,28]	$6,350/$12,700[10,11]	$12,700/$25,400[10,11]
MAXIMUM BENEFIT WHILE INSURED	Unlimited	Unlimited	Unlimited	Unlimited	$5,000,000[24]
IN THE MEDICAL OFFICE Primary care visits	$60 (after deductible)[2]	$30 (after deductible)	40% (after deductible)	$60 (after deductible)[2]	50% (after deductible)
Urgent care visits	$60 (after deductible)[2]	$30 (after deductible)	40% (after deductible)	$120 (after deductible)[2]	50% (after deductible)
Specialty office visits	$70 (after deductible)	$30 (after deductible)	40% (after deductible)	$70 (after deductible)	50% (after deductible)
Preventive exams	$0	$0	$0	$0[12]	50% (after deductible)[12]
Prenatal care	$0[3]	$0	$0	$0[13,14]	50% (after deductible)[13,14]
Postpartum care	$0[3]	$0 (after deductible)	$0 (after deductible)	30% (after deductible)	50% (after deductible)
Well-child preventive care visits	$0[25]	$0[25]	$0[25]	$0	50% (after deductible)
Vaccines (immunizations)	$0	$0	$0	$0	50% (after deductible)
Allergy injections	$5 (after deductible)	$5 (after deductible)	40% (after deductible)	$60 (after deductible)[2]	50% (after deductible)
Infertility services	Not covered	Not covered	Not covered	50% (after deductible)[15]	Not covered
Occupational, physical, and speech therapy	$60 (after deductible)	$30 (after deductible)	40% (after deductible)	$60 (after deductible)[16]	50% (after deductible)[16]
Most laboratory tests	30% (after deductible)	$30 (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)
Most X-rays and diagnostic	30% (after deductible)	$30 (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)
Most MRI/CT/PET scans	30% (after deductible)	30% (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)
Outpatient surgery	30% per procedure (after deductible)	30% per procedure (after deductible)	40% per procedure (after deductible)	30% (after deductible)	50% (after deductible)[17]
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$300 (after deductible)	30% (after deductible)	40% (after deductible)	$300 (after deductible)	$300 (after deductible)
Ambulance	$300 (after deductible)	30% (after deductible)	40% (after deductible)	$300 (after deductible)[4]	$300 (after deductible)[4]
PRESCRIPTIONS Generic drugs	(up to a 30-day supply) $19 (after deductible)[26]	(up to a 30-day supply) $15 (after deductible)[26]	(up to a 100-day supply) 40% (after deductible)[26]	(up to a 30-day supply) $19 (after deductible)[18,19,20]	
Brand-name drugs	(up to a 30-day supply) $50 (after deductible)[26]	(up to a 30-day supply) $40 (after deductible)[26]	(up to a 100-day supply) 40% (after deductible)[26]	(up to a 30-day supply) $50 (after deductible)[18,19,20]	
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% (after deductible)	30% (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)[21]
Skilled nursing facility care (up to 100 days per benefit period)	30% (after deductible)	30% (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)[21]
MENTAL HEALTH SERVICES In the medical office	$60[2]	$30 (after deductible)	40% (after deductible)	$60 (after deductible)[2]	50% (after deductible)
In the hospital	30% (after deductible)	30% (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)[21]
CHEMICAL DEPENDENCY SERVICES In the medical office	$60[2]	$30 (after deductible)	40% (after deductible)	$60 (after deductible)[2]	50% (after deductible)
In the hospital (detoxification only)	30% (after deductible)	30% (after deductible)	40% (after deductible)	30% (after deductible)	50% (after deductible)[21]
OTHER Certain durable medical equipment (DME)	30% (after deductible)[6]	30% (after deductible)[6]	40% (after deductible)[6]	30% (after deductible)[22,23]	50% (after deductible)[22,23]
Certain prosthetics, orthotics, and devices	$0[6]	$0 (after deductible)[6]	$0 (after deductible)[6]	30% (after deductible)	50% (after deductible)
Pediatric optical (eyewear)	One pair of frames, lenses, or contact lenses per calendar year[7]	One pair of frames, lenses, or contact lenses per calendar year[7]	One pair of frames, lenses, or contact lenses per calendar year[7]	30% for one pair of frames, lenses, or contact lenses per calendar year[7]	
Pediatric vision exam	$0	$0	$0	$0	$0
Adult optical (eyewear)	Not covered[8]	Not covered[8]	Not covered[8]	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	$0	$0	$0	Not covered
Home health care (up to 100 visits per calendar year)	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)	50% (after deductible)
Hospice care	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)	$0 (after deductible)[27]

Please refer to the Footnotes for medical plans on page 8.

Kaiser Permanente Silver Tier

Plan Highlights

For effective dates 1/1/14–12/1/14

***ALSO AVAILABLE IN COVERED CALIFORNIA**

	Silver 1000/40	Silver 1500/45*	Silver HSA 1500/20%*	Silver PPO 1500/45 Pending regulatory approval	
FEATURES	**Deductible HMO Plan**	**Deductible HMO Plan**	**HSA-Qualified Deductible HMO Plan**	**Participating providers (in-network)[9]**	**Non-participating providers (out-of-network)[9]**
ANNUAL PLAN DEDUCTIBLE Individual/Family	$1,000/$2,000[10]	$1,500/$3,000[10]	$1,500/$3,000[28]	$1,500/$3,000[10]	$3,000/$6,000[10]
PHARMACY ANNUAL DEDUCTIBLE Brand-name drugs	$0	$500 (per individual)	$0[30]	$500 (per individual)[32]	
ANNUAL OUT-OF-POCKET MAXIMUM Individual/Family	$6,350/$12,700[1,10]	$6,350/$12,700[1,10]	$6,350/$12,700[1,28]	$6,350/$12,700[10,11]	$12,700/$25,400[10,11]
MAXIMUM BENEFIT WHILE INSURED	Unlimited	Unlimited	Unlimited	Unlimited	$5,000,000[24]
IN THE MEDICAL OFFICE Primary care visits	$40	$45	20% (after deductible)	$45	40% (after deductible)
Urgent care visits	$40	$45	20% (after deductible)	$90	40% (after deductible)
Specialty office visits	$40	$65	20% (after deductible)	$65	40% (after deductible)
Preventive exams	$0	$0	$0	$0[12]	40% (after deductible)[12]
Prenatal care	$0[3]	$0[3]	$0	$0[13,14]	40% (after deductible)[13,14]
Postpartum care	$0[3]	$0[3]	$0 (after deductible)	20% (after deductible)	40% (after deductible)
Well-child preventive care visits	$0[25]	$0[25]	$0[25]	$0	40% (after deductible)
Vaccines (immunizations)	$0	$0	$0	$0	40% (after deductible)
Allergy injections	$5	$5	20% (after deductible)	$45	40% (after deductible)
Infertility services	Not covered	Not covered	Not covered	50%[15]	Not covered
Occupational, physical, and speech therapy	$40	$45	20% (after deductible)	$45[16]	40% (after deductible)[16]
Most laboratory tests	$30	$45	20% (after deductible)	$45	40% (after deductible)
Most X-rays and diagnostic	$40	$65	20% (after deductible)	$65	40% (after deductible)
Most MRI/CT/PET scans	30% (after deductible)	$250	20% (after deductible)	20% (after deductible)	40% (after deductible)
Outpatient surgery	30% per procedure (after deductible)	20% per procedure	20% per procedure (after deductible)	20%	40% (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	30% (after deductible)	$250 (after deductible)	20% (after deductible)	$250 (after deductible)	$250 (after deductible)
Ambulance	30% (after deductible)	$250 (after deductible)	20% (after deductible)	$250 (after deductible)[4]	$250 (after deductible)[4]
PRESCRIPTIONS Generic drugs	(up to a 30-day supply) $25[26]	(up to a 30-day supply) $19[26]	(up to a 100-day supply) 20% (after deductible)[26]	(up to a 30-day supply) $19[18,19,20,32]	
Brand-name drugs	(up to a 30-day supply) $50[26]	(up to a 30-day supply) $50 (after brand-name deductible)[26]	(up to a 100-day supply) 20% (after deductible)[26]	(up to a 30-day supply) $50 (after brand-name deductible)[18,19,20,32]	
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	30% (after deductible)	20% (after deductible)	20% (after deductible)	20% (after deductible)[5]	40% (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	30% (after deductible)	20% (after deductible)	20% (after deductible)	20% (after deductible)	40% (after deductible)
MENTAL HEALTH SERVICES In the medical office	$40	$45	20% (after deductible)	$45	40% (after deductible)
In the hospital	30% (after deductible)	20% (after deductible)	20% (after deductible)	20% (after deductible)	40% (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$40	$45	20% (after deductible)	$45	40% (after deductible)
In the hospital (detoxification only)	30% (after deductible)	20% (after deductible)	20% (after deductible)	20% (after deductible)	40% (after deductible)
OTHER Certain durable medical equipment (DME)	30%[6]	20%[6]	20% (after deductible)[6]	20%[22,23]	40% (after deductible)[22,23]
Certain prosthetics, orthotics, and devices	$0[6]	$0[6]	$0 (after deductible)[6]	20%	40% (after deductible)
Pediatric optical (eyewear)	One pair of frames, lenses, or contact lenses per calendar year[7]	One pair of frames, lenses, or contact lenses per calendar year[7]	One pair of frames, lenses, or contact lenses per calendar year[7]	20% for one pair of frames, lenses, or contact lenses per calendar year[7]	
Pediatric vision exam	$0	$0	$0	$0	$0
Adult optical (eyewear)	Not covered[8]	Not covered[8]	Not covered[8]	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	$0	$0	$0	Not covered
Home health care (up to 100 visits per calendar year)	$0	$0	$0 (after deductible)	$0	40% (after deductible)
Hospice care	$0	$0	$0 (after deductible)	$0	40% (after deductible)[27]

Please refer to the Footnotes for medical plans on page 8.

Kaiser Permanente Gold Tier

Plan Highlights

For effective dates 1/1/14–12/1/14

***ALSO AVAILABLE IN COVERED CALIFORNIA**

	Gold 0/30*	Gold 500/30	Gold HRA 2000/30	Gold PPO 0/30 Pending regulatory approval	
FEATURES	Copayment HMO Plan	Deductible HMO Plan	Deductible HMO with HRA Plan	Participating providers (in-network)[9]	Non-participating providers (out-of-network)[9]
ANNUAL PLAN DEDUCTIBLE Individual/Family	$0	$500/$1,000[10]	$2,000/$4,000[10]	$0	$1,000/$2,000[10]
PHARMACY ANNUAL DEDUCTIBLE Brand-name drugs	$0	$0	$0	$0	
ANNUAL OUT-OF-POCKET MAXIMUM Individual/Family	$6,350/$12,700[1,31]	$6,350/$12,700[1,10]	$6,350/$12,700[1,10]	$6,350/$12,700[10,11]	$12,700/$25, 400[10,11]
MAXIMUM BENEFIT WHILE INSURED	Unlimited	Unlimited	Unlimited	Unlimited	$5,000,000[24]
IN THE MEDICAL OFFICE Primary care visits	$30	$30	$30	$30	40% (after deductible)
Urgent care visits	$30	$30	$30	$60	40% (after deductible)
Specialty office visits	$50	$30	$30	$50	40% (after deductible)
Preventive exams	$0	$0	$0	$0[12]	40% (after deductible)[12]
Prenatal care	$0[3]	$0[3]	$0[3]	$0[13,14]	40% (after deductible)[13,14]
Postpartum care	$0[3]	$0[3]	$0[3]	20%	40% (after deductible)
Well-child preventive care visits	$0[25]	$0[25]	$0[25]	$0	40% (after deductible)
Vaccines (immunizations)	$0	$0	$0	$0	40% (after deductible)
Allergy injections	$5	$5	$5 (after deductible)	$30	40% (after deductible)
Infertility services	Not covered	Not covered	Not covered	50%[15]	Not covered
Occupational, physical, and speech therapy	$30	$30	$30 (after deductible)	$30[16]	40% (after deductible)[16]
Most laboratory tests	$30	$20	20% (after deductible)	$30	40% (after deductible)
Most X-rays and diagnostic	$50	$20	20% (after deductible)	$50	40% (after deductible)
Most MRI/CT/PET scans	$250	$250	20% (after deductible)	20%	40% (after deductible)
Outpatient surgery	$600 per procedure	$600 per procedure (after deductible)	20% (after deductible)	20%	40% (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$250	$250 (after deductible)	20%	$250	$250
Ambulance	$250	$250 (after deductible)	20% (after deductible)	$250[4]	$250[4]
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$19[26]	$20[26]	$15[26]	$19[18,19,20]	
Brand-name drugs (up to a 30-day supply)	$50[26]	$50[26]	$30[26]	$50[18,19,20]	
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$600 per day up to 5 days per admission[29]	$600 per day up to 5 days per admission (after deductible)[29]	20% (after deductible)	20%	40% (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	$300 per day up to 5 days per admission[29]	$250 per day up to 5 days per admission (after deductible)[29]	20% (after deductible)	20%	40% (after deductible)
MENTAL HEALTH SERVICES In the medical office	$30	$30	$30	$30	40% (after deductible)
In the hospital	$600 per day up to 5 days per admission[29]	$600 per day up to 5 days per admission (after deductible)[29]	20% (after deductible)	20%	40% (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$30	$30	$30	$30	40% (after deductible)
In the hospital (detoxification only)	$600 per day up to 5 days per admission[29]	$600 per day up to 5 days per admission (after deductible)[29]	20% (after deductible)	20%	40% (after deductible)
OTHER Certain durable medical equipment (DME)	20%[6]	20%[6]	50%[6]	20%[22,23]	40% (after deductible) [22,23]
Certain prosthetics, orthotics, and devices	$0[6]	$0[6]	$0[6]	20%	40% (after deductible)
Pediatric optical (eyewear)	One pair of frames, lenses, or contact lenses per calendar year[7]	One pair of frames, lenses, or contact lenses per calendar year[7]	One pair of frames, lenses, or contact lenses per calendar year[7]	20% for one pair of frames, lenses, or contact lenses per calendar year[7]	
Pediatric vision exam	$0	$0	$0	$0	$0
Adult optical (eyewear)	Not covered[8]	Not covered[8]	Not covered[8]	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	$0	$0	$0	Not covered
Home health care (up to 100 visits per calendar year)	$0	$0	$0	20%	40% (after deductible)
Hospice care	$0	$0	$0	$0	40% (after deductible)[27]

Please refer to the Footnotes for medical plans on page 8.

Kaiser Permanente Platinum Tier

Plan Highlights

For effective dates 1/1/14–12/1/14

***ALSO AVAILABLE IN COVERED CALIFORNIA**

	Platinum 0/20*	Platinum PPO 0/20 Pending regulatory approval	
FEATURES	**Copayment HMO Plan**	**Participating providers (in-network)[9]**	**Non-participating providers (out-of-network)[9]**
ANNUAL PLAN DEDUCTIBLE Individual/Family	$0	$0	$500/$1,000[10]
PHARMACY ANNUAL DEDUCTIBLE Brand-name drugs	$0	$0	
ANNUAL OUT-OF-POCKET MAXIMUM Individual/Family	$4,000/$8,000[1,31]	$4,000/$8,000[10,11]	$8,000/$16,000[10,11]
MAXIMUM BENEFIT WHILE INSURED	Unlimited	Unlimited	$5,000,000[24]
IN THE MEDICAL OFFICE Primary care visits	$20	$20	30% (after deductible)
Urgent care visits	$20	$40	30% (after deductible)
Specialty office visits	$40	$40	30% (after deductible)
Preventive exams	$0	$0[12]	30% (after deductible)[12]
Prenatal care	$0[3]	$0[13,14]	30% (after deductible)[13,14]
Postpartum care	$0[3]	10%	30% (after deductible)
Well-child preventive care visits	$0[25]	$0	30% (after deductible)
Vaccines (immunizations)	$0	$0	30% (after deductible)
Allergy injections	$5	$20	30% (after deductible)
Infertility services	Not covered	50%[15]	Not covered
Occupational, physical, and speech therapy	$20	$20[16]	30% (after deductible)[16]
Most laboratory tests	$20	$20	30% (after deductible)
Most X-rays and diagnostic	$40	$40	30% (after deductible)
Most MRI/CT/PET scans	$150	10%	30% (after deductible)
Outpatient surgery	$250 per procedure	10%	30% (after deductible)
EMERGENCY SERVICES Emergency Department visits (waived if admitted directly to hospital)	$150	$150	$150
Ambulance	$150	$150[4]	$150[4]
PRESCRIPTIONS Generic drugs (up to a 30-day supply)	$5[26]	$5[18,19,20]	
Brand-name drugs (up to a 30-day supply)	$15[26]	$15[18,19,20]	
HOSPITAL CARE Physicians' services, room and board, tests, medications, supplies, therapies, birth services	$250 per day up to 5 days per admission[29]	10%	30% (after deductible)
Skilled nursing facility care (up to 100 days per benefit period)	$150 per day up to 5 days per admission[29]	10%	30% (after deductible)
MENTAL HEALTH SERVICES In the medical office	$20	$20	30% (after deductible)
In the hospital	$250 per day up to 5 days per admission[29]	10%	30% (after deductible)
CHEMICAL DEPENDENCY SERVICES In the medical office	$20	$20	30% (after deductible)
In the hospital (detoxification only)	$250 per day up to 5 days per admission[29]	10%	30% (after deductible)
OTHER Certain durable medical equipment (DME)	10%[6]	10%[22,23]	30% (after deductible)[22,23]
Certain prosthetics, orthotics, and devices	$0[6]	10%	30% (after deductible)
Pediatric optical (eyewear)	One pair of frames, lenses, or contact lenses per calendar year[7]	10% for one pair of frames, lenses, or contact lenses per calendar year[7]	
Pediatric vision exam	$0	$0	$0
Adult optical (eyewear)	Not covered[8]	Not covered	Not covered
Adult vision exam (for eye refraction)	$0	$0	Not covered
Home health care (up to 100 visits per calendar year)	$0	10%	30% (after deductible)
Hospice care	$0	$0	30% (after deductible)[27]

Please refer to the Footnotes for medical plans on page 8.

Footnotes for medical plans

Cost share amounts for all in-network services accumulate toward the annual out-of-pocket maximum.

Preventive services are available at no cost share. For a complete list of preventive services please refer to the *Evidence of Coverage, Certificate of Insurance,* or **businessnet.kp.org**.

Kaiser Permanente plans do not include a pre-existing condition clause.

[1]Annual out-of-pocket maximum is the maximum amount an individual or family will pay for certain services in a calendar year.

[2]Deductible waived for first three visits combined for primary care, urgent care, and individual mental/behavioral health and substance use disorder services.

[3]Scheduled prenatal visits and the first postpartum visit

[4]The PHCS network does not contract for ambulance service. Therefore, medically necessary nonemergency ambulance service is payable at the non-participating providers level.

[5]Deductible does not apply for physician/surgeon fee.

[6]Please refer to the *Evidence of Coverage* for more information on DME, prosthetics, orthotics, and devices. Most DME for home use, prosthetics, orthotics, and devices are not covered.

[7]For 0 up to age 19

[8]Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be combined with any other Health Plan vision benefit. The discounts will not 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.

[9]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.

[10]This plan carries an embedded deductible. Each family member becomes eligible for benefits after meeting the individual deductible, or when the family deductible is satisfied. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

[11]Covered charges incurred toward satisfaction of the out-of-pocket maximum at the non-participating providers tier will not accumulate toward satisfaction of the out-of-pocket maximum on the PHCS network tier. Likewise, covered charges incurred toward satisfaction of the out-of-pocket maximum at the PHCS network tier will not accumulate toward satisfaction of the out-of-pocket maximum on the non-participating providers tier.

[12]Preventive lab tests, X-rays, and immunizations are covered as part of the preventive exam. Routine adult physical exams are limited to one exam every 12 months.

[13]Routine prenatal care office visits are covered as required under the Affordable Care Act (ACA). This includes the initial and subsequent histories, physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis.

[14]Delivery and inpatient care for mother and baby are covered under your inpatient services benefit. For a complete understanding of birth services, please see your KPIC *Certificate of Insurance*.

[15]Benefits payable for treatment of infertility are limited to $1,000 per calendar year for services provided by PHCS network providers. Infertility includes GIFT. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as any other illness.

[16]All outpatient therapies, except those associated with autism spectrum disorders, or services in accordance with the California Early Intervention Services Act for children under age 3 are limited to 60 visits per calendar year combined for both PHCS network and non-participating providers.

[17]KPIC pays a maximum of $600 per procedure for outpatient surgery services from non-participating providers.

[18]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.

[19]Your plan does not have a prescription 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.

[20]Self-administered injectable medications are covered under your plan, are limited to a 30-day maximum supply, and are not available under the mail-order service. Prescriptions for insulin are covered under the Brand or Generic cost share amounts. Regardless of your provider, prescriptions can be filled at a MedImpact participating pharmacy. Please call MedImpact at 800-788-2949 for a participating pharmacy.

[21]KPIC pays a maximum of $600 per day for all hospital care received from non-participating providers, excluding physician, surgeon, and surgical services.

[22]Certain DME and supplies are limited to a combined maximum benefit of $2,000 per calendar year for services from PHCS network and non-participating providers, excluding diabetic testing supplies and equipment.

[23]Diabetic equipment and supplies are limited to infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes, and transparent film. Coinsurance amounts are based on actual billed charges and are not subject to the DME annual maximum limit of $2,000 per calendar year.

[24]Maximum benefit while insured applies to covered charges from non-participating providers only.

[25]Well-child visits through age 23 months

[26]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 copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments. Please refer to your *Disclosure Forms for Kaiser Permanente for Small Business* book for mail-order incentive.

[27]Hospice care is limited to a 180-day maximum benefit while insured for services from non-participating providers.

[28]This plan carries an aggregate deductible. The entire family deductible must be met before copayments apply for individual family members.

[29]After the 5 days, the hospital stay for the same admission is covered at no charge.

[30]Pharmacy cost shares are subject to the annual plan deductible.

[31]A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied.

[32]Annual pharmacy deductible contributes to the out-of-pocket maximum for the in-network providers.

Dental plans

Choose from a variety of dental plans, which you can pair with any of our medical plans for greater flexibility and access. These plans are administered by Delta Dental of California, one of the nation's largest and most experienced dental benefits providers.

Pediatric dental plans

For effective dates 1/1/14–12/1/14

Pediatric dental services is one of the essential health benefits required to be provided in conjunction with your ACA metal-tier medical plan(s). When employees and their dependents enroll in the medical plan(s) you've chosen, we will also enroll them in a separate pediatric dental plan underwritten by Delta Dental of California. Pediatric dental plans are paired with medical plans based on metal tier, except for embedded PPO plans.

	HMO	HMO	PPO
	For Bronze and Silver medical plans	For Gold and Platinum medical plans	For all metal-tier PPO medical plans
SERVICES	Member pays	Member pays	Member pays
DEDUCTIBLE	$0	$0	$0
ANNUAL OUT-OF-POCKET (OOP) MAXIMUM	$1,000/child $2,000/multichild	$1,000/child $2,000/multichild	N/A[1]
WAITING PERIODS (MAJOR AND ORTHO)	N/A	N/A	N/A
OFFICE VISIT	$20	$0	N/A
PREVENTIVE Periodic and comprehensive – oral evaluation	$0	$0	$0
Bitewing X-rays	$0	$0	$0
Prophylaxis cleaning	$0	$0	$0
Fluoride treatments	$0	$0	$0
Space maintainers	$0	$0	$0
Sealants	$0	$0	$0
PERIODONTICS Maintenance	Not covered	Not covered	Not covered
Scaling and root planing	$120	$70	50%
Surgery – osseous (includes flap entry and closure)	$510	$310	50%
RESTORATIVE Fillings – primary or permanent amalgam	$120	$45	50%
Composite crowns – resin-based	$170	$110	50%
Crown – porcelain	$560	$560	50%
Inlay – metallic	Not covered	Not covered	Not covered
ENDODONTICS Therapeutic pulpotomy	$90	$50	50%
Root amputation	$180	$110	50%
Root canal – anterior	$320	$200	50%
Root canal – molar	$460	$280	50%
PROSTHODONTICS Complete denture	$710	$710	50%
Reline maxillary denture – chairside and limitations is "Partial"	$150	$150	50%
Reline maxillary denture – laboratory and limitations is "Partial"	$210	$210	50%
Extraction – erupted tooth or exposed root	$80	$50	50%
Surgical removal of erupted tooth	$130	$80	50%
ORTHODONTICS (MEDICALLY NECESSARY)	$1,000[2]	$1,000[2]	50%

Footnotes:
[1]No separate OOP Maximum – applied to medical OOP Maximum
[2]Orthodontics includes medically necessary orthodontia only.

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Kaiser Permanente Insurance Company
KPIC Fee-for-Service (Premier) dental plans

For effective dates 1/1/14–12/1/14

These dental insurance plans are underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California. The plans below are not intended to satisfy the ACA pediatric dental benefits.

	PLAN C	PLAN D	PLAN E	PLAN E WITH ORTHO[1]	LIMITATIONS
SERVICE	**PLAN PAYS[2]**	**PLAN PAYS[2]**	**PLAN PAYS[2]**	**PLAN PAYS[2]**	
NO DEDUCTIBLE APPLIES TO THESE PROCEDURES.					
Exam	100%	100%	100%	100%	Twice in a calendar year
Bitewing X-rays X-rays of the top and bottom molars and premolars to show decay between teeth or under fillings	100%	100%	100%	100%	Twice in a calendar year for children through age 18, or once in a calendar year for adults ages 19 and over
Other X-rays	80%	80%	80%	80%	Full-mouth X-rays, single X-rays, and panographic X-rays once in any five-year period
Prophylaxis A professional cleaning to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	100%	100%	100%	Twice in a calendar year
Fluoride treatments A treatment with a chemical compound that prevents cavities and makes the tooth surface stronger so the teeth can resist decay	100%	100%	100%	100%	Only for children through age 18, twice in a calendar year
DEDUCTIBLES APPLY TO PROCEDURES UNDER PLANS D, E, AND E WITH ORTHODONTICS.					
Calendar-year deductible	No deductible	$25	$25	$25	Per person, per calendar year, up to a family maximum of $75 per calendar year
Annual benefit maximum	$500	$1,000	$1,000	$1,000	Annual benefit maximum represents the total annual amount paid by the plan per person, per calendar year
Palliative care Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms; the goal is to prevent and relieve suffering and improve quality of life	80%	80%	80%	80%	Usual, customary, and reasonable
Denture relines	Not covered	80%	80%	80%	Twice in a calendar year (limited to two upper, two lower, or any combination)[3]
Space maintainers	100%	100%	100%	100%	Usual, customary, and reasonable
Fillings	80%	80%	80%	80%	Usual, customary, and reasonable
Stainless steel crowns	80%	80%	80%	80%	Primary teeth only
Endodontics A dental specialty concerned with treatment of the root and nerve of the tooth	Not covered	80%	80%	80%	Usual, customary, and reasonable
Periodontics A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	Not covered	80%	80%	80%	Usual, customary, and reasonable
Oral surgery	Not covered	80%	80%	80%	Usual, customary, and reasonable
Crowns and cast restorations The artificial covering of a tooth with metal porcelain or porcelain fused to metal; covers teeth that are weakened by decay or severely damaged or chipped	Not covered	Not covered	50%	50%	Includes replacements after five years, but only if originally covered by KPIC dental plan
Prosthodontics A dental specialty concerned with restoration and/or replacement of missing teeth with artificial materials	Not covered	Not covered	50%	50%	Standard removable prosthetic appliance (includes replacements after five years, but only if originally covered by KPIC dental plan)
Orthodontics A dental specialty concerned with straightening or moving misaligned teeth and/or jaws with braces and/or surgery	Not covered	Not covered	Not covered	50%	For eligible dependent children through age 18, $1,500 lifetime maximum per insured (Replacement or repair of an orthodontic appliance paid for in part or in full by this plan is not covered.)

[1]Plan E with Orthodontics requires at least 10 subscribers.
[2]Benefits payable will be based on the lesser of the usual, customary, and reasonable fees or the fees actually charged.
[3]Limitation applies only to Plan D.

KAISER PERMANENTE®
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Kaiser Permanente Insurance Company
KPIC PPO dental plans

For effective dates 1/1/14–12/1/14

These dental insurance plans are underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California. The plans below are not intended to satisfy the ACA pediatric dental benefits.

	PPO D 1500		PPO E 1000		PPO E 1500		LIMITATIONS
SERVICE	PLAN PAYS[1] (PPO NETWORK)	PLAN PAYS (OUT-OF-NETWORK)	PLAN PAYS[1] (PPO NETWORK)	PLAN PAYS (OUT-OF-NETWORK)	PLAN PAYS[1] (PPO NETWORK)	PLAN PAYS (OUT-OF-NETWORK)	
NO DEDUCTIBLE APPLIES TO THESE PROCEDURES.							
Exam	100%	50%	100%	50%	100%	50%	Twice in a calendar year
Bitewing X-rays X-rays of the top and bottom molars and premolars to show decay between teeth or under fillings	100%	50%	100%	50%	100%	50%	Twice in a calendar year for children through age 18, or once in a calendar year for adults ages 19 and over
Other X-rays	80%	50%	80%	50%	80%	50%	Full-mouth X-rays, single X-rays, and panographic X-rays once in any five-year period
Prophylaxis A professional cleaning to remove plaque, calculus (mineralized plaque), and stains to help prevent dental disease	100%	50%	100%	50%	100%	50%	Twice in a calendar year
Fluoride treatments A treatment with a chemical compound that prevents cavities and makes the tooth surface stronger so the teeth can resist decay	100%	50%	100%	50%	100%	50%	Only for children through age 18, twice in a calendar year
DEDUCTIBLES APPLY TO PROCEDURES BELOW.							
Calendar-year deductible	$25	$50	$25	$50	$25	$50	Per person, per calendar year, up to a family maximum of $75 (in network) and $150 (out-of-network)
Annual benefit maximum	$1,500	$1,500	$1,000	$1,000	$1,500	$1,500	Annual benefit maximum represents the total annual amount paid by the plan per person, per calendar year
Palliative care Any form of medical care or treatment that concentrates on reducing the severity of disease symptoms; the goal is to prevent and relieve suffering and improve quality of life	80%	50%	80%	50%	80%	50%	
Denture relines	80%	50%	80%	50%	80%	50%	Twice in a calendar year
Space maintainers	100%	50%	100%	50%	100%	50%	
Fillings	80%	50%	80%	50%	80%	50%	
Stainless steel crowns	80%	50%	80%	50%	80%	50%	Primary teeth only
Endodontics A dental specialty concerned with treatment of the root and nerve of the tooth	80%	50%	80%	50%	80%	50%	
Periodontics A dental specialty concerned with the treatment of gums, tissue, and bone that supports the teeth	80%	50%	80%	50%	80%	50%	
Oral surgery	80%	50%	80%	50%	80%	50%	
Crowns and cast restorations The artificial covering of a tooth with metal porcelain or porcelain fused to metal; covers teeth that are weakened by decay or severely damaged or chipped	Not covered	Not covered	50%	50%	50%	50%	Includes one replacement in any five-year period, but only if originally covered by KPIC dental plan
Prosthodontics A dental specialty concerned with restoration and/or replacement of missing teeth with artificial material	Not covered	Not covered	50%	50%	50%	50%	Standard removable prosthetic appliances (includes one replacement in any five-year period, but only if originally covered by KPIC dental plan)
Orthodontics A dental specialty concerned with straightening or moving misaligned teeth and/or jaws with braces and/or surgery	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

[1]Benefits payable will be based on the maximum allowable charge.

DeltaCare HMO plans

For effective dates 1/1/14–12/1/14

DeltaCare USA is underwritten and administered by Delta Dental of California.
The plans below are not intended to satisfy the ACA pediatric dental benefits.

	DELTACARE 10A	DELTACARE 13B	
SERVICES	MEMBER PAYS	MEMBER PAYS	LIMITATIONS
PREVENTIVE CARE			
Periodic and comprehensive – oral evaluation	No cost	No cost	Twice in a calendar year
Bitewing X-rays	No cost	No cost	Twice in a calendar year for children through age 18, or once in a calendar year for adults ages 19 and over
Prophylaxis	No cost	No cost	Twice in a calendar year
Fluoride treatments	No cost	No cost	Only for children up to age 19, twice in a calendar year
Space maintainers	$10	$50	Removable – unilateral
PERIODONTICS			
Maintenance	No cost	$35	Twice in a calendar year
Scaling and root planing	No cost	$50	Limited to four quadrants per calendar year
Surgery – osseous (includes flap entry and closure)	$175	$300	Four or more teeth per quadrant
RESTORATIVE			
Fillings – primary or permanent amalgam	No cost	No cost	Four or more surfaces
Composite crowns – resin-based	No cost	$55	Anterior
Crown – porcelain	$195	$355	
Inlay – metallic	No cost	$145	One surface
ENDODONTICS			
Therapeutic pulpotomy	No cost	$25	Excludes final restoration
Root amputation	No cost	$70	Per root
Root canal – anterior	$45	$95	Excludes final restoration
Root canal – molar	$205	$335	Excludes final restoration
PROSTHODONTICS			
Complete denture	$100	$285	The enrollee must continue to be eligible, and the service must be provided at the contract dentist facility where the denture was originally delivered.
Reline maxillary or mandibular denture – chairside	No cost	$50	Complete or partial
Reline maxillary or mandibular denture – laboratory	$35	$85	Complete or partial
ORAL AND MAXILLOFACIAL SURGERY			
Extraction – erupted tooth or exposed root	No cost	$5	Elevation and/or forceps removal
Surgical removal of erupted tooth	$15	$45	Complete or partial
ORTHODONTICS			
Comprehensive orthodontic – child	$1,700	$1,900	Child or adolescent to age 19
Comprehensive orthodontic – adult	$1,900	$2,100	Adults, including covered dependent adult children

Benefits listed above are only a sample of provided services and associated costs. Costs will vary. Please see the *Evidence of Coverage* for a comprehensive list of all services and costs. DeltaCare benefits are only covered when performed by an in-network California DeltaCare HMO provider. In California, DeltaCare USA is underwritten and administered by Delta Dental of California.

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Important information for the KPIC Fee-for-Service (Premier) and PPO dental insurance plans

The following services are not covered under any Kaiser Permanente Insurance Company (KPIC) group dental insurance plans:

- The KPIC plans are not intended to satisfy the ACA pediatric dental benefits.
- Any treatment or procedure not listed as covered.
- Charges in excess of the maximum allowable charge.
- Services for injuries or conditions covered under workers' compensation or employer's liability laws.
- Cosmetic surgery, dentistry, or services to correct hereditary, congenital, or developmental malformations.
- Restoration of tooth structure crowns, and/or cast restorations, or chewing surfaces for damages due to wear.
- Prosthodontic services or procedures started prior to a person's date of eligibility.
- Prescribed drugs, premedication, or pain relievers.
- Experimental procedures.
- Hospital costs or extra charges for hospital treatment.
- Anesthesia (except general anesthesia for oral surgery).
- Extra-oral grafts, implants, or implant removal.
- Treatment related to the temporomandibular joint (TMJ).
- Plaque-control programs, oral hygiene, or dietary instructions.
- Orthodontic treatment, except for eligible dependent children under Plan E with Orthodontics.
- Treatment plans that are more expensive than those customarily provided, or specialized techniques used instead of standard procedures; for example, a precision denture where a standard denture would suffice.
- Pit and fissure sealants, except for first molars of children through age 8 and second molars for children through age 15. The molar must have no decay and no restoration, and the occlusal surface must be intact. Coverage does not include the repair or replacement of a sealant on any tooth within three years of application.
- Services provided to the covered person by any federal or state governmental agency or provided without cost to the covered person by any municipality, county, or other political subdivision, except Medi-Cal benefits.
- Charges by any hospital or other surgical treatment facility, or any additional fees charged by the dentist for treatment in any such facility.
- Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants.
- Replacement of existing restoration for any purpose other than active tooth decay.
- Intravenous sedation, occlusal guards, or complete occlusal adjustment.
- Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
- Hypnosis.
- Charges for completion of forms.
- Charges for speech therapy.
- Charges for lost or stolen appliances.
- Services for which no charge is normally made in the absence of insurance.

Predetermination of benefits is recommended for services in excess of $300. This document is not intended as a summary plan description, nor is it designed to serve as the *Certificate of Insurance* or the *Schedule of Coverage*. It contains only a summary of benefits, exclusions, and limitations. If you have specific questions regarding benefit structure, limitations, or exclusions, consult the *Certificate of Insurance* and the *Schedule of Coverage* or contact Delta Dental's Customer Service Department at 800-835-2244, 8 a.m. to 5 p.m., Monday through Friday. For a list of in-network providers, contact Delta Dental's Customer Service Department. This dental insurance plan is underwritten by Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., and administered by Delta Dental of California.

Exclusions of benefits for the DeltaCare HMO dental plans

Exclusions

- The DeltaCare HMO plans are not intended to satisfy the ACA pediatric dental benefits.
- The DeltaCare HMO dental plan is not available for employees enrolled in a PPO medical plan and living outside of California.
- Any procedure that in the professional opinion of the contract dentist:
  - has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
  - is inconsistent with generally accepted standards for dentistry.
- Services solely for cosmetic purposes, with the exception of procedure D9972 (external bleaching, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
- Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns, and fixed partial dentures (bridges) for children under 16 years of age.
- Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns, and fixed partial dentures (bridges).
- Procedures, appliances, or restoration, if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
- Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith), and personalization and characterization of complete and partial dentures.
- Implant-supported dental appliances and attachments; implant placement, maintenance, or removal; and all other services associated with a dental implant.
- Consultations for noncovered benefits.
- Dental services received from any dental facility other than the assigned contract dentist, a preauthorized dental specialist, or a contract orthodontist except for Emergency Services as described in the contract and/or *Evidence of Coverage*.
- All related fees for admission, use, or stays in a hospital, outpatient surgery center, extended care facility, or other similar care facility.
- Prescription drugs.
- Dental expenses incurred in connection with any dental or orthodontic procedure started before the enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken, and orthodontics unless qualified for the orthodontic treatment in progress provision.
- Lost, stolen, or broken orthodontic appliances.
- Changes in orthodontic treatment necessitated by accident of any kind.
- Myofunctional and parafunctional appliances and/or therapies.
- Composite or ceramic brackets, lingual adaptation of orthodontic bands, and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
- Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services.

For additional benefit information or a directory of Delta dentists, please call Delta Dental at **800-422-4234** or visit **deltadentalins.com**.

Chiropractic and acupuncture plans

Your employees can get the care they need with our combined coverage for chiropractic and acupuncture care — and they don't need a referral from their primary care doctor.

Chiropractic and Acupuncture Plan — $15 Copay/20 Visits

SERVICES ARE ADMINISTERED BY AMERICAN SPECIALTY HEALTH PLANS OF CALIFORNIA, INC.® (ASH PLANS)	
FEATURES	**$15 COPAY/20 VISITS**
Office visit copayment	$15 per visit
Office visit limit	20 combined visits per calendar year
Chiropractic appliance benefit	Chiropractic appliances are provided up to a maximum of $50 per calendar year when prescribed and provided by an ASH Plans participating chiropractor as part of your chiropractic care.
X-rays and laboratory tests	$0

Services

Chiropractic services are covered when a participating chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders. Acupuncture services are covered when a participating acupuncturist finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders, nausea, or pain. You can obtain services from any ASH Plans participating chiropractors and acupuncturists without a referral from a Kaiser Permanente Plan physician.

Office visits: Covered services are limited to medically necessary chiropractic and acupuncture services authorized and provided by ASH Plans participating chiropractors and acupuncturists.

X-rays and laboratory tests: Medically necessary X-rays and laboratory tests are covered when prescribed as part of your chiropractic care by a participating chiropractor and provided by an appropriately licensed participating provider that has contracted with ASH Plans to provide those services.

Emergency services: Covered chiropractic services are those emergency services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system. Covered acupuncture services are those emergency services provided for the sudden and unexpected treatment of a neuromusculoskeletal disorder, nausea, or pain. These conditions and injuries must manifest themselves by acute symptoms of sufficient severity, including severe pain, such that a reasonable layperson with no special knowledge of health, medicine, chiropractic care, or acupuncture could reasonably expect that a delay of immediate chiropractic care or acupuncture could result in (1) placing your health in serious jeopardy, (2) serious impairment to your bodily functions, or (3) serious dysfunction of any bodily organ or part.

Participating chiropractors and acupuncturists

ASH Plans contracts with participating chiropractors and other participating providers to provide covered chiropractic services, including laboratory tests, X-rays, and chiropractic appliances. ASH Plans

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contracts with participating acupuncturists to provide acupuncture care (including adjunctive therapies, such as acupressure, cupping, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture). You must receive covered services from a participating provider, except for emergency chiropractic and acupuncture services and services that are not available from participating providers that are previously authorized by ASH Plans. The list of participating chiropractors and acupuncturists is available on the ASH Plans website at **ashcompanies.com/kp** or from the ASH Plans Member Services Department at **800-678-9133.** The list of participating chiropractors and acupuncturists is subject to change at any time without notice.

How to obtain covered services

To obtain covered services, call a participating chiropractor or acupuncturist to schedule an initial examination. If additional services are required, your participating chiropractor or acupuncturist will prepare a treatment plan. The ASH Plans Clinical Services Manager will authorize the treatment plan if the services are medically necessary chiropractic services and acupuncture services for you. ASH Plans will disclose to you, upon request, the process that it uses to authorize a treatment plan. If you have questions or concerns, please contact the ASH Plans Member Services Department.

This is a summary and is intended to highlight only the most frequently asked questions about the chiropractic and acupuncture benefit, including copayments. **This benefit cannot be offered with the HSA-qualified deductible HMO plans, or the PPO plans.** Please refer to the *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for a detailed description of the chiropractic and acupuncture benefits, including exclusions and limitations, emergency chiropractic services, and emergency acupuncture services.

Kaiser Foundation Health Plan, Inc. (Health Plan), contracts with American Specialty Health Plans of California, Inc. (ASH Plans), to make the ASH Plans network of participating chiropractors and participating acupuncturists available to you. You can obtain covered services from any participating chiropractor or participating acupuncturist without a referral from a Plan physician. Cost sharing is due when you receive covered services. Please see the definitions section of your *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for terms you should know.

Getting assistance

If you have a question or concern regarding the services you received from a participating provider, you may call ASH Plans Member Services at **800-678-9133** (TTY users call **711**) weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

ASH Plans Member Services
P.O. Box 509002
San Diego, CA 92150-9002

Dispute resolution

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as why you believe a decision was in error or why you are dissatisfied with services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *Evidence of Coverage*.

Chiropractic and Acupuncture Plan for The Kaiser Permanente PPO Insurance Plans – $15 Copay/20 Visits

FEATURES	PPO INSURANCE PLANS $15 COPAY/20 VISITS
Office visit copayment	$15 per visit
Office visit limit	20 combined visits per calendar year
Chiropractic appliance benefit	Chiropractic appliances are covered under medical plan DME benefits when prescribed by a PHCS participating chiropractor as part of your care.
X-rays and laboratory tests	30% (covered under PPO medical plans)

Services

You can obtain chiropractic and acupuncture services from any participating provider without a referral from a physician. Except for the initial examination, your chiropractic benefits are limited to medically necessary chiropractic services for the treatment or diagnosis of neuromusculoskeletal disorders that are due to subluxation and are treatable by manual manipulation of the spine.

Office visits: Covered services are limited to medically necessary chiropractic and acupuncture services authorized and provided by a PHCS network provider.[1]

How to obtain services

You must receive chiropractic or acupuncture services from a participating provider in the PHCS network.[2] Choose from more than 2,000 providers in California and thousands of others nationwide. To find a provider near you, visit **multiplan.com/kaiser**. Deductibles or copayments paid under the chiropractic and acupuncture coverage do not count toward satisfying your medical deductible and out-of-pocket maximum.

Chiropractic and acupuncture coverage for the Kaiser Permanente PPO Insurance Plans is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. This is only a summary of your benefits and is intended to highlight only the most frequently asked questions about the chiropractic and acupuncture benefit, including copayments. Benefits may vary depending on the terms of your plan. Please refer to the KPIC *Certificate of Insurance* and *Schedule of Coverage* for a detailed description of your chiropractic and acupuncture benefits, including exclusions, limitations, and emergency chiropractic services.

[1]It is possible that your chiropractor may perform physical therapy–related services not covered under your chiropractic benefits. Please refer to your KPIC *Certificate of Insurance* for complete details about which services are covered.

[2]KPIC has contracted with PHCS to give you access to providers with a commitment to keeping out-of-pocket costs low through contracted rates.

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Small Business
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