

Gold 80 HDHP HMO 1900/15% PCP + Child Dental ALT*†

For effective dates January 1 - December 1, 2026

Principal benefits for Kaiser Permanente for Small Business

“Kaiser Permanente for Small Business” is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the *EOC*.

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	\$4,500 ¹	\$4,500 ¹	\$9,000 ¹
Plan Deductible	\$1,900 ¹	\$3,400 ¹	\$3,800 ¹
Drug Deductible	Not applicable	Not applicable	Not applicable

Plan Provider Office Visits

Most Primary Care Visits and most Non-Physician Specialist Visits	You Pay 15% Coinsurance after Plan Deductible
Most Physician Specialist Visits.....	15% Coinsurance 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	15% Coinsurance after Plan Deductible
Most physical, occupational, and speech therapy	15% Coinsurance after Plan Deductible

Telehealth Visits

Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	You Pay No charge after Plan Deductible
Physician Specialist Visits by interactive video or telephone	No charge after Plan Deductible

Outpatient Services

Outpatient surgery and certain other outpatient procedures	You Pay 15% Coinsurance after Plan Deductible
Most immunizations (including the vaccine).....	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	15% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i>	No charge (Plan Deductible doesn't apply)

Hospital Inpatient Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	You Pay 15% Coinsurance after Plan Deductible
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Emergency Services

Emergency department visits	You Pay 15% 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

Ambulance Services	You Pay 15% Coinsurance after Plan Deductible
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Prescription Drug Coverage

Covered outpatient items in accord with our drug formulary guidelines:	You Pay
Most generic items (Tier 1) at a Plan Pharmacy.....	\$15 for up to a 30-day supply after Plan Deductible
Most generic (Tier 1) refills through our mail-order service	\$30 for up to a 100-day supply after Plan Deductible
Most brand-name items (Tier 2) at a Plan Pharmacy	\$45 for up to a 30-day supply after Plan Deductible
Most brand-name (Tier 2) refills through our mail-order service	\$90 for up to a 100-day supply after Plan Deductible

Prescription Drug Coverage

Most specialty items (Tier 4) at a Plan Pharmacy	You Pay 15% Coinsurance (not to exceed \$250) for up to a 30-day supply after Plan Deductible
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Durable Medical Equipment (DME)

Base DME items as described in the <i>EOC</i>	You Pay 15% Coinsurance after Plan Deductible
Supplemental DME items up to a \$2,000 benefit limit per Accumulation Period as described in the <i>EOC</i>	15% Coinsurance after Plan Deductible

Mental Health Services

Inpatient psychiatric hospitalization	You Pay 15% Coinsurance after Plan Deductible
Outpatient mental health evaluation and treatment	15% Coinsurance after Plan Deductible

Substance Use Disorder Treatment

Inpatient detoxification	You Pay 15% Coinsurance after Plan Deductible
Outpatient substance use disorder evaluation and treatment	15% Coinsurance after Plan Deductible

Home Health Services

Home health care (up to 100 visits per Accumulation Period)	You Pay 15% Coinsurance after Plan Deductible
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Other

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 <i>EOC</i> ...	You Pay No charge (Plan Deductible doesn't apply)
Skilled nursing facility care (up to 100 days per benefit period)	15% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge after Plan Deductible
Chiropractic and acupuncture	15% per visit after deductible for physician-referred acupuncture only
Pediatric vision exam	No charge
Adult optical (eyewear)	Not covered ²

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

† The abbreviation "ALT," in certain plan names, indicates Kaiser Permanente developed plans.

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. 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.

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

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.