KAISER PERMANENTE®

Platinum 90 HMO 0/10 PCP + Child Dental ALT*†

For effective dates January 1 - December 1, 2027

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.

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	$4,800[1]	$4,800[1]	$9,600[1]
Plan Deductible	None[1]	None[1]	None[1]
Drug Deductible	None	None	None

Plan Provider Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$30 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (up to and including 23 months)	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$10 per visit
Most physical, occupational, and speech therapy	$10 per visit

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

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$400 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays	$50 per encounter
Most laboratory tests	$25 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge
MRI, most CT, and PET scans	$150 per procedure

Hospital Inpatient Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per admission

Emergency Services and Care	You Pay
Emergency department visits	$200 per visit

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	$150 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$10 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service	$20 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy	$20 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	$40 for up to a 100-day supply

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Prescription Drug Coverage	You Pay
Most specialty items (Tier 4) at a Plan Pharmacy	10% Coinsurance (not to exceed $250) for up to a 30-day supply
Durable Medical Equipment (DME)	**You Pay**
Base DME items as described in the *EOC*	10% Coinsurance
Supplemental DME items up to a $2,000 benefit limit per Accumulation Period as described in the *EOC*	10% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$500 per admission
Individual outpatient mental health evaluation and treatment	No charge
Group outpatient mental health treatment	No charge
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$500 per admission
Individual outpatient substance use disorder evaluation and treatment	No charge
Group outpatient substance use disorder treatment	No charge
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
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
Eyeglasses or contact lenses every 24 months for Adult Members	Amount in excess of $175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	$250 per admission
Prosthetic and orthotic devices as described in the *EOC*	No charge
Fertility Services (such as outpatient procedures or laboratory tests)	Not covered[2]
Chiropractic and acupuncture	$15 per visit (self-referral; 20 combined visits per year)
Pediatric vision exam	No charge

* 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. 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.