Proposed Benefit Summary

Benefit Plan 13860
CS $5,000 DED, $50 OV, 30% IP
, $15/$50/30% RX

Principal Benefits for Kaiser Permanente Deductible HMO Plan (1/1/22—12/31/22)

Accumulation Period

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

Out-of-Pocket Maximum(s) and Deductible(s)

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 deductible(s) 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	$7,000	$7,000	$14,000
Plan Deductible	$5,000	$5,000	$10,000
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$50 per visit after Plan Deductible*
Most Physician Specialist Visits	$50 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)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	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	$50 per visit after Plan Deductible*
Most physical, occupational, and speech therapy	$50 per visit after Plan Deductible

*The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the *EOC*.

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	30% Coinsurance after Plan Deductible
Allergy antigens (including administration)	$5 per visit after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	30% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Plan Deductible

Emergency Health Coverage	You Pay
Emergency Department visits	30% 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 "Hospitalization Services" for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	30% Coinsurance after Plan Deductible

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$15 for up to a 30-day supply after Plan Deductible
Most generic refills through our mail-order service	$30 for up to a 100-day supply after Plan Deductible
Most brand-name items at a Plan Pharmacy	$50 for up to a 30-day supply after Plan Deductible
Most brand-name refills through our mail-order service	$100 for up to a 100-day supply after Plan Deductible
Most specialty items at a Plan Pharmacy	30% Coinsurance (not to exceed $250) for up to a 30-day supply after Plan Deductible
Preventive items as described in the *EOC*	$10 for up to a 100-day supply (Plan Deductible doesn't apply)

(continues)

Proposed Benefit Summary *(continued)*

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	30% Coinsurance (Plan Deductible doesn't apply)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	30% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$50 per visit after Plan Deductible*
Group outpatient mental health treatment	$25 per visit after Plan Deductible*

*The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the *EOC*.

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	30% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$50 per visit after Plan Deductible*
Group outpatient substance use disorder treatment	$5 per visit after Plan Deductible*

*The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the *EOC*.

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	30% Coinsurance after Plan Deductible
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
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge (Plan Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).