2022 Benefit Summary	HSA-qualified PPO Plan 13918 NCR / 13919 SCR	
	Participating Provider Tier[16]*	**Non-Participating Provider Tier***
	Precertification is required for certain services†	
The Accumulation Period for this Plan is **Calendar Year**		
Maximum benefit while insured	Unlimited	
	Insured pays	
Deductible per accumulation period[1][2][3]	$3,000 Individual $6,000 Family	$5,000 Individual $10,000 Family
Out-of-Pocket Maximum per accumulation period[4]	$6,000 Individual $12,000 Family	$12,000 Individual $24,000 Family
Hospital care		
Room, board, and critical care units	20% (after deductible)	40% (after deductible)
Imaging, including X-rays and lab tests	20% (after deductible)	40% (after deductible)
Transplants	20% (after deductible)	40% (after deductible)
Physician, surgeon, and surgical services	20% (after deductible)	40% (after deductible)
Nursing care, anesthesia, and inpatient prescribed drugs	20% (after deductible)	40% (after deductible)
Birth Services[8]	20% (after deductible)	40% (after deductible)
Outpatient care		
Physician office visits	$40 Copayment (after deductible)	40% (after deductible)
Specialty care	$40 Copayment (after deductible)	40% (after deductible)
Telehealth visits[9]	$40 Copayment (after deductible)	40% (after deductible)
Preventive screening services	No charge[3]	40%[3]
Routine adult physical exam	No charge[3][5]	Not covered
Well-child preventive care visits	No charge[3][6]	40%[6]
Family planning visits	$40 Copayment (after deductible)	40% (after deductible)
Prenatal care[7]	No charge[3]	40%[3]
Outpatient Surgery	20% per procedure (after deductible)	40% per procedure (after deductible)
Lab Test and Imaging, including X-rays	20% (after deductible)	40% (after deductible)
Hearing exams	No charge[3]	Not covered
Occupational, physical, respiratory, and speech therapy visits	20% (after deductible)	40% (after deductible)
Health Education	No charge[3]	Not covered
Diabetic Day Care Management Classes	No charge[3]	40% (after deductible)
Emergency Care (Emergency Copayment waived if admitted)	$150 Copayment, then 20% (after deductible)	
Emergency Ambulance Service	40% (after deductible)	40% (after deductible)
Medically Necessary Non-emergency Ambulance Service	40% (after deductible)	40% (after deductible)
Urgent Care	20% (after deductible)	40% (after deductible)

2022 Benefit Summary	HSA-qualified PPO Plan 13918 NCR / 13919 SCR	
	Participating Provider Tier[16]*	**Non-Participating Provider Tier***
	Precertification is required for certain services†	
	Insured pays	
Prescriptions[10]	**MedImpact Pharmacies**[11][17]	**Non-Participating Pharmacies**
Generic drugs (30-day supply)	$15 Copayment (after deductible)	Not covered
Brand drugs (30-day supply)	$40 Copayment (after deductible)	Not covered
Contraceptive drugs	No charge	Not covered
Specialty drugs[12]	30% with $250 per script maximum (after deductible)	Not covered
Mail-order generic drugs (maximum benefit of a 100-day supply)	$30 Copayment (after deductible)	Not covered
Mail-order brand drugs (maximum benefit of a 100-day supply)	$80 Copayment (after deductible)	Not covered
Mental health care		
Inpatient hospitalization	20% (after deductible)	40% (after deductible)
Outpatient individual therapy visits	$40 Copayment (after deductible)	40% (after deductible)
Outpatient group therapy visits	$20 Copayment (after deductible)	40% (after deductible)
Substance use disorder treatment		
Inpatient hospitalization	20% (after deductible)	40% (after deductible)
Outpatient individual therapy visits	$40 Copayment (after deductible)	40% (after deductible)
Outpatient group therapy visits	$20 Copayment (after deductible)	40% (after deductible)
Durable medical equipment	20%[14] (after deductible)	40%[14] (after deductible)
Diabetic Equipment and Supplies[15]	20% (after deductible)	20% (after deductible)
Prosthetics, orthotics, and special footwear	20% (after deductible)	40% (after deductible)
Additional benefits		
Care in a skilled-nursing facility (60-day combined limit per benefit period)[18]	20% (after deductible)	40% (after deductible)
Home health care (100-day combined limit per accumulation period)[18]	20% (after deductible)	20% (after deductible)
Hospice care	20% (after deductible)	40% (after deductible)
Fertility services	20% (after deductible)	40% (after deductible)

Note: These benefits are subject to regulatory approval.

This chart only describes a summary of the benefits. For a complete understanding of benefits, please read this summary in conjunction with the Kaiser Permanente Insurance Company *Certificate of Insurance*, which contains a complete explanation of benefits, exclusions, and limitations. The information provided in this Benefit Summary is not intended for use as a Summary Plan Description, nor is it designed to serve as the *Certificate of Insurance*.

Footnotes

(1) This plan carries an embedded Deductible and Out-of-Pocket Maximum. Benefits become payable for each family member after their individual annual Deductible is met, or when the family Deductible is satisfied. Deductibles contribute towards satisfying the Out-of-Pocket Maximum. A family member can meet the individual annual Out-of-Pocket Maximum before the family Out-of-Pocket Maximum is satisfied.

(2) Covered Charges incurred toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Participating Provider Tier will accumulate toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Participating Provider Tier. Likewise, Covered Charges incurred toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Non-Participating Provider Tier will accumulate toward satisfaction of the Deductible or Out-of-Pocket Maximum on the Non-Participating Provider Tier.

(3) Deductibles, Coinsurance and Copayments do not apply to Preventive Benefits required under the Patient Protection Affordable Care Act (PPACA) provided by Participating Providers. Preventive Benefits received at the Non-Participating Provider Tier are subject to Coinsurance and Copayments.

(4) Out of Pocket Maximums are separate for services provided by Participating Providers and Non-Participating Providers. Covered charges applied towards the satisfaction of the Deductible may also be applied to the Out of Pocket Maximum.

(5) Routine adult physical exams are limited to one exam every 12 months.

(6) Well-child preventive care includes immunizations and is exempt from Deductibles.

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

(8) Birth Services including 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 *Certificate of Insurance* .

(9) Telehealth care is provided where applicable and available via communication methods such as telephone, video, or email. Cost shares vary depending on the type of service provided and are equivalent to an in-person visit specific to that service.

(10) Member is responsible for paying the brand name Copayment plus the difference in cost between the generic drug and the brand name drug when patient requests brand name drug and a generic version is prescribed by the physician.

(11) MedImpact Pharmacy Copayment and Coinsurance are subject to the satisfaction of the Deductible or the Out-of-Pocket Maximum. Select prescription drugs are excluded from coverage.

(12) Specialty Drugs are not available under the mail order service.

(13) Benefits payable for treatment of infertility are limited to $1,000 per accumulation period combined for services provided by Participating Providers or Non-Participating Providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as a sickness.

(14) Certain Durable Medical Equipment is limited to a maximum of $2,000 per accumulation period combined for services provided by Participating Providers and Non-Participating Providers.

(15) 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 accumulation period.

(16) An online directory of Participating Providers can be found by visiting www.multiplan.com/kaiser.

(17) An online directory of Pharmacies available to you can be found by visiting kp.org/pharmacylocator/ppo.

(18) The visit maximum does not apply to medically necessary treatment of Mental Health and Substance Use Disorder.

†Precertification of services provided by Participating Providers and Non-Participating Providers
Precertification is required for all hospital confinements, including preadmission testing, inpatient care at a skilled-nursing facility, or other licensed, freestanding facilities, such as hospice care, home health care, or care at a rehabilitation facility, and select outpatient procedures. Failure to obtain precertification will result in a penalty of $500 per occurrence for Covered Charges incurred in connection with these services. This penalty will not count toward the satisfaction of any Calendar Year Deductibles or Out-of-Pocket Maximums.

***Based on Maximum Allowable Charge for Covered Services**
Payments are based upon the Maximum Allowable Charge for Covered Services. Maximum Allowable Charge means the lesser of: the Usual, Customary, and Reasonable Charges; or 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.

HSA-qualified PPO Benefits are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP).