

Proposed Benefit Summary

Benefit Plan 13051

\$3,500 DED, 30% OV, 30% IP, 30%/30%/30% RX

Principal Benefits for Kaiser Permanente Deductible HMO Plan with HRA (1/1/23—12/31/23)

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	\$6,500	\$6,500	\$13,000
Plan Deductible	\$3,500	\$3,500	\$7,000
Drug Deductible	None	None	None

Plan Provider Office Visits

Most Primary Care Visits and most Non-Physician Specialist Visits.....
 Most Physician Specialist Visits.....
 Routine physical maintenance exams, including well-woman exams
 Well-child preventive exams (through age 23 months)
 Scheduled prenatal care exams
 Routine eye exams with a Plan Optometrist.....
 Urgent care consultations, evaluations, and treatment
 Most physical, occupational, and speech therapy

You Pay

30% Coinsurance after Plan Deductible
 30% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)
 30% Coinsurance after Plan Deductible
 30% Coinsurance after Plan Deductible

Telehealth Visits

Primary Care Visits and Non-Physician Specialist Visits by interactive video
 Physician Specialist Visits by interactive video
 Primary Care Visits and Non-Physician Specialist Visits by telephone..
 Physician Specialist Visits by telephone.....

You Pay

No charge (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)

Outpatient Services

Outpatient surgery and certain other outpatient procedures
 Most immunizations (including the vaccine).....
 Most X-rays and laboratory tests
 Preventive X-rays, screenings, and laboratory tests as described in the EOC.....

You Pay

30% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)
 30% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)

Hospitalization Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....

You Pay

30% Coinsurance after Plan Deductible

Emergency Health Coverage

Emergency Department visits.....

You Pay

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

Ambulance Services.....

You Pay

30% Coinsurance after Plan Deductible

Prescription Drug Coverage

Covered outpatient items in accord with our drug formulary guidelines:

You Pay

Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service 30% Coinsurance (not to exceed \$50) for up to a 100-day supply (Plan Deductible doesn't apply)
 Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service 30% Coinsurance (not to exceed \$100) for up to a 100-day supply (Plan Deductible doesn't apply)

Proposed Benefit Summary*(continued)*

Prescription Drug Coverage

You Pay

Most specialty items (Tier 4) at a Plan Pharmacy 30% Coinsurance (not to exceed \$250) for up to a 30-day supply (Plan Deductible doesn't apply)

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 30% Coinsurance after Plan Deductible
Group outpatient mental health treatment 30% Coinsurance after Plan Deductible

Substance Use Disorder Treatment

You Pay

Inpatient detoxification 30% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment 30% Coinsurance after Plan Deductible
Group outpatient substance use disorder treatment 30% Coinsurance after Plan Deductible

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 (such as outpatient procedures or laboratory tests) as described in the *EOC* 50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services Not covered
Hospice care No charge (Plan Deductible doesn't apply)

This proposal is a summary and does not include all benefits, member cost share, out-of-pocket maximums, exclusions, or limitations. For a complete description, please refer to the *Evidence of Coverage*.