2023 Benefit Summary	Kaiser Permanente Point-of-Service Plan 13894 NCR / 13895 SCR		
	HMO Tier (Kaiser Permanente Plan Providers)	**Participating Provider Tier[19] ***	**Non-Participating Provider Tier***
		Precertification is required for certain services†	
The Accumulation Period for this Plan is **Calendar Year**			
Maximum benefit while insured	Unlimited		
	Member pays		
Deductible per accumulation period[1]	None	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Out-of-Pocket Maximum per accumulation period[2]	$2,500 Individual $5,000 Family	$4,500 Individual $9,000 Family	$9,000 Individual $18,000 Family
Hospital care	$500 Copayment per admission, then	$500 Copayment per admission, then	$1,000 Copayment per admission, then
Room and board, including obstetrics	No charge	20%	50%
Imaging, including X-rays and lab tests	No charge	20%	50%
Physician, surgeon, and surgical services	No charge	20%	50%
Nursing care, anesthesia, and medications	No charge	20%	50%
Birth Services[6]	No charge	20%	50%
Outpatient care			
Physician office visits	$30 Copayment	20%	50%
Specialty Care	$30 Copayment	20%	50%
Telehealth visits[8]	No charge	20%	50%
Preventive screening services	No charge	No charge[3]	50%[3]
Routine adult physical exams	No charge	No charge[3][4]	Not covered
Well-child preventive care visits	No charge	No charge[3]	50%[3]
Family planning visits	No charge	20%	50%
Scheduled prenatal and first post-partum visits[5]	No charge	No charge[3]	50%[3]
Outpatient surgery	$250 Copayment per procedure	20% per procedure	50% per procedure
Imaging, including X-rays and lab tests	$10 Copayment	20%	50%
Hearing exams	No charge	Covered under the HMO Tier Only	Covered under the HMO Tier Only
Physical, occupational, and speech therapy visits	$30 Copayment	20%	50%
Health education	No charge	Covered under the HMO Tier Only	Covered under the HMO Tier Only
Emergency Care (Copayment waived if admitted directly to hospital)	Covered under the HMO Tier, subject to a $150 Copayment, regardless of facility/hospital accessed[7]		
Emergency Ambulance Service	Covered under the HMO Tier, subject to a $150 charge		
Medically Necessary Non-emergency ambulance service	$150	50%	50%
Urgent Care	$30 Copayment	20%	50%

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		Precertification is required for certain services†	
	Member pays		
Prescriptions[9] **(30-day supply)**	**Kaiser Permanente Pharmacies**	**MedImpact Pharmacies**[10][20]	**Non-Participating Pharmacies**
Generic preferred tier	$10 Copayment	$20 Copayment	Not covered
Generic non-preferred tier	$10 Copayment[18]	$50 Copayment	Not covered
Brand preferred tier	$30 Copayment	$40 Copayment	Not covered
Brand non-preferred tier	$30 Copayment [18]	$50 Copayment	Not covered
Specialty tier[17]	20% with $250 per prescription maximum	30% with $250 per prescription maximum	Not covered
Mail-order Prescriptions			
Generic drugs (maximum 100-day supply)	$20 Copayment	Most prescriptions from Participating/Non-Participating Providers may be filled at Kaiser Permanente Pharmacies and refilled through mail-order. Mail-order service is not available at MedImpact Pharmacies.	
Brand preferred drugs (maximum 100-day supply)	$60 Copayment		
Mental health services			
Inpatient hospitalization	$500 Copayment per admission	$500 Copayment per admission, then 20%	$1,000 Copayment per admission, then 50%
Outpatient individual therapy visits	$30 Copayment	20%	50%
Outpatient group therapy visits	$15 Copayment	20%	50%
Substance use disorder treatment			
Inpatient hospitalization	$500 Copayment per admission	$500 Copayment per admission, then 20%	$1,000 Copayment per admission, then 50%
Outpatient individual therapy visits	$30 Copayment	20%	50%
Outpatient group therapy visits	$5 Copayment	20%	50%
Durable medical equipment	30%	30%[14]	50%[14]
Diabetic Equipment and Supplies[15]	30%	30%	30%
Prosthetics, orthotics, and special footwear[16]	No charge	20%	50%
Additional benefits			
Skilled nursing facility care[21]	$500 Copayment (100-day limit per benefit period)	$500 Copayment per admission, then 20%[11]	$1,000 Copayment per admission, then 50%[11]
Home health care (100-day limit per accumulation period)[21]	No charge	20%[3][12]	20%[3][12]
Hospice care	No charge	20%	50%
Fertility services	$30 Copayment	20%[3][13]	50%[3][13]

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 the Kaiser Permanente Point-of-Service Disclosure Form and Evidence of Coverage and the Kaiser Permanente Insurance Company *Certificate of Insurance*. The Disclosure Form, Evidence of Coverage, and the *Certificate of Insurance* together contain a complete explanation of benefits, exclusions, and limitations. The information provided in this chart is not intended for use as a Summary Plan Description, the Disclosure Form, Evidence of Coverage, or the *Certificate of Insurance*.

Footnotes

(1) Deductible amounts are separate for services provided by Participating Providers and Non-Participating Providers. 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 applied to satisfy the Out-of-Pocket Maximum at the Participating Provider Tier will not apply toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider Tier. Likewise, Covered Charges applied to satisfy the Out-of-Pocket Maximum at the Non-Participating Provider Tier will not apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider Tier. For a complete understanding of the Out-of-Pocket Maximum, please refer to your *Certificate of Insurance*.

(3) Exempt from Deductible.

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

(5) 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.

(6) 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*.

(7) Emergency medical services are covered under the HMO Tier. Non-emergency medical services received in an emergency care setting that are not covered under the HMO Tier may be eligible for coverage under the Participating Provider or Non-Participating Provider Tiers.

(8) 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 except when using the HMO tier where the cost share is $0 (no charge).

(9) MedImpact Pharmacy Copayment and Coinsurance are not subject to, nor do they contribute toward satisfaction of the Deductible. However, they do contribute toward the satisfaction of the Out-of-Pocket Maximum. Select prescription drugs are excluded from coverage.

(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) Skilled Nursing Facility care is limited to a maximum of 60 days per benefit period combined for services provided by Participating Providers and Non-Participating Providers.

(12) Home Health Care is limited to a maximum of 100 visits per accumulation period combined for services provided by Participating Providers and Non-Participating Providers.

(13) Benefits payable for treatment of infertility are limited to $1,000 per accumulation period combined for services provided by Participating Providers and 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.

Covered Charges for infertility services do not accumulate towards satisfaction of the Out-of-Pocket Maximum.

(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. Certain Durable Medical Equipment is not subject to the Deductible nor contributes to the Out-of-Pocket Maximum.

(15) Some diabetic equipment and supplies such as: infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes and transparent film are payable based on actual billed charges and are not subject to the DME annual maximum of $2,000 per accumulation period.

(16) Most items are not covered.

(17) Specialty drugs are not eligible for mail order incentive and may not be available under the mail order service.

(18) Non-preferred drugs are covered at a Kaiser Permanente pharmacy only when prescribed by Kaiser Permanente Plan Providers through exception process or when related to emergency care, out-of-area urgent care, or an authorized referral.

(19) Online directories of Participating Providers available to you can be found by visiting kp.org/kpic/pos.

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

(21) 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, or selected 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 Deductibles or Out-of-Pocket Maximums. For a complete understanding of precertification requirements, please refer to your *Certificate of Insurance*.

***Payments Based on 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 are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service.

The HMO Tier of the Point-of-Service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) while the Participating Provider and Non-Participating Provider Tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.