**Proposed Benefit Summary**

**Benefit Plan 16072**
**$35/$50 OV, 20% IP, 20% ER, $15/$40/20% RX**

# Principal Benefits for Kaiser Permanente HMO Plan with Coinsurance (1/1/24—12/31/24)

## 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 | $4,000 | $4,000 | $8,000 |
| Plan Deductible | None | None | None |
| Drug Deductible | None | None | None |

| Plan Provider Office Visits | You Pay |
|---|---|
| Most Primary Care Visits and most Non-Physician Specialist Visits | $35 per visit |
| Most Physician Specialist Visits | $50 per visit |
| Routine physical maintenance exams, including well-woman exams | No charge |
| Well-child preventive exams (through age 23 months) | No charge |
| Scheduled prenatal care exams | No charge |
| Routine eye exams with a Plan Optometrist | No charge |
| Urgent care consultations, evaluations, and treatment | $35 per visit |
| Most physical, occupational, and speech therapy | $35 per visit |

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

| Outpatient Services | You Pay |
|---|---|
| Outpatient surgery and certain other outpatient procedures | 20% Coinsurance |
| Most immunizations (including the vaccine) | No charge |
| Most X-rays and laboratory tests | $15 per encounter |
| Preventive X-rays, screenings, and laboratory tests as described in the *EOC* | No charge |
| MRI, most CT, and PET scans | 20% Coinsurance up to a maximum of $150 per procedure |

| Hospitalization Services | You Pay |
|---|---|
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | 20% Coinsurance |

| Emergency Health Coverage | You Pay |
|---|---|
| Emergency Department visits | 20% Coinsurance |

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 | $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 | $15 for up to a 30-day supply |
| Most generic (Tier 1) refills through our mail-order service | $30 for up to a 100-day supply |
| Most brand-name items (Tier 2) at a Plan Pharmacy | $40 for up to a 30-day supply |
| Most brand-name (Tier 2) refills through our mail-order service | $80 for up to a 100-day supply |
| Most specialty items (Tier 4) at a Plan Pharmacy | 20% Coinsurance (not to exceed $250) for up to a 30-day supply |


*(continues)*

**Proposed Benefit Summary** *(continued)*

| **Durable Medical Equipment (DME)** | **You Pay** |
|---|---|
| DME items as described in the *EOC* | 50% Coinsurance |
| **Mental Health Services** | **You Pay** |
| Inpatient psychiatric hospitalization | 20% Coinsurance |
| Individual outpatient mental health evaluation and treatment | $35 per visit |
| Group outpatient mental health treatment | $17 per visit |
| **Substance Use Disorder Treatment** | **You Pay** |
| Inpatient detoxification | 20% Coinsurance |
| Individual outpatient substance use disorder evaluation and treatment | $35 per visit |
| Group outpatient substance use disorder treatment | $5 per visit |
| **Home Health Services** | **You Pay** |
| Home health care (up to 100 visits per Accumulation Period) | No charge |
| **Other** | **You Pay** |
| Skilled nursing facility care (up to 100 days per benefit period) | No charge |
| Prosthetic and orthotic devices as described in the *EOC* | No charge |
| Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC* | 50% Coinsurance |
| Assisted reproductive technology (“ART”) Services | Not covered |
| Hospice care | No charge |

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*.