Benefit Plan 13047 CS \$2,000 DED, \$20 OV, 20% IP , \$10/\$30/20% 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.

Internet         Year or more Members         Members           Plan Out-of-Pocket Maximum         \$4,500         \$4,500         \$9,000           Plan Deductible         \$2,000         \$2,000         \$4,000           Drug Deductible         None         None         None           Professional Services (Plan Provider office visits)         You Pay         None         None           Most Physical maintenance exams, including well-woman exams.         No charge (Plan Deductible doesn't apply)         No charge (Plan Deductible doesn't apply)           Routine physical maintenance exams.         No charge (Plan Deductible doesn't apply)         No charge (Plan Deductible doesn't apply)           Scheduled prenatal care exams.         No charge (Plan Deductible doesn't apply)         No charge (Plan Deductible doesn't apply)           Scheduled prenatal care exams.         No charge (Plan Deductible doesn't apply)         No charge (Plan Deductible doesn't apply)           Scheduled prenatal care exams.         No charge (Plan Deductible doesn't apply)         You Pay           Outpatient Services         You Pay         200 per visit (Plan Deductible doesn't apply)           Untaget sin donatory tests.         20% Coinsurance after Plan Deductible doesn't apply)           Most Physical maintenance (ream therapy sing and laboratory tests as described in the EOC.         No charge (Plan Deductible doesn't apply)	Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of	Family Coverage Entire Family of two or more	
Plan Deductible         \$2,000         \$2,000         \$2,000         \$2,000           Drug Deductible         None         None         None         None           Professional Services (Plan Provider office visits)         You Pay         \$20 per visit (Plan Deductible doesn't apply)           Most Physical anspecialist Visits         \$20 per visit (Plan Deductible doesn't apply)         \$20 per visit (Plan Deductible doesn't apply)           Routine physical maintenance exams, including well-woman exams.         No charge (Plan Deductible doesn't apply)           Scheduled prenatal care exams.         No charge (Plan Deductible doesn't apply)           Scheduled prenatal care exams.         No charge (Plan Deductible doesn't apply)           Scheduled prenatal care exams.         No charge (Plan Deductible doesn't apply)           Outpatient Services         You Pay           Nost X-rays and laboratory tests as described in the ECC         No charge (Plan Deductible doesn't apply)           Most X-rays and laboratory tests, and drugs.         20% Coinsurance after Plan Deductible	Diana Out of De clust Maximum	· · ·			
Drug Deductible         None         None         None           Professional Services (Plan Provider office visits)         You Pay           Most Primary Care Visits and most Non-Physician Specialist Visits         \$20 per visit (Plan Deductible doesn't apply)           Routine physician Specialist Visits         \$20 per visit (Plan Deductible doesn't apply)           Routine physician Specialist Visits         \$20 per visit (Plan Deductible doesn't apply)           Routine physician Specialist Visits         \$20 per visit (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)           Outpatient Surgery and certain other outpatient procedures         \$20 per visit (Plan Deductible doesn't apply)           Outpatient Surgery and certain other outpatient procedures         20% Coinsurance after Plan Deductible doesn't apply)           Most rays, screenings, and laboratory tests as described in the EOC.         No charge (Plan Deductible doesn't apply)           Most rays, screenings, and laboratory tests, and drugs.         20% Coinsurance after Plan Deductible doesn't apply)           Most rays, screenings, and laboratory tests, and drugs.         20% Coinsurance after Plan Deductible           Remegnery Department vi					
Professional Services (Plan Provider office visits)         You Pay           Most Privation Specialist Visits         \$20 per visit (Plan Deductible doesn't apply)           Most Privation Specialist Visits         \$20 per visit (Plan Deductible doesn't apply)           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)           Scheduled prenatal care exams.         No charge (Plan Deductible doesn't apply)           Scheduled prenatal care exams.         No charge (Plan Deductible doesn't apply)           Most physical, occupational, and speech therapy.         \$20 per visit (Plan Deductible doesn't apply)           Most physical, occupational, and speech therapy.         \$20 per visit (Plan Deductible doesn't apply)           Outpatient Services         20% Coinsurance after Plan Deductible doesn't apply)           Most invinzitions (including the vaccine)         No charge (Plan Deductible doesn't apply)           Most invinzitions (including the vaccine)         No charge (Plan Deductible doesn't apply)           Most invinzitions (including the vaccine)         No charge (Plan Deductible doesn't apply)           Most invinzitions (including the vaccine)         No charge (Plan Deductible doesn't apply)           Most invinzitions (including the vaccine)         No charge (Plan Deductible doesn't apply)		. ,	. ,	· /	
Most Primary Care Visits and most Non-Physician Specialist Visits       \$20 per visit (Plan Deductible doesn't apply)         Most Physician Specialist Visits       \$20 per visit (Plan Deductible doesn't apply)         Routine physical maintenance exams, including well-woman exams.       No charge (Plan Deductible doesn't apply)         Year       Year       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)         Most Physical, occupational, and speech therapy.       \$20 per visit (Plan Deductible doesn't apply)         Most Physical, occupational, and speech therapy.       \$20 per visit (Plan Deductible doesn't apply)         Outpatient Services       You Pay         Outpatient Services       20% Coinsurance after Plan Deductible doesn't apply)         Most Furya antigens (including the vaccine)       No charge (Plan Deductible doesn't apply)         Most munizations (including the vaccine)       No charge (Plan Deductible doesn't apply)         Most munizations (including the vaccine)       No charge (Plan Deductible doesn't apply)         Most munizations (including the vaccine)       No charge (Plan Deductible doesn't apply)         Most munizations (including the vaccine)       No charge (Plan Deductible doesn't apply)         Most munizations (including the vaccine)	V V			None	
Most Physician Specialist Visits       \$20 per visit (Plan Deductible doesn't apply)         Noutine physical maintenance exams, including well-woman exams.       No charge (Plan Deductible doesn't apply)         Yell-child preventive exams (through age 23 months).       No charge (Plan Deductible doesn't apply)         Scheduled prentati care exams.       No charge (Plan Deductible doesn't apply)         Routine eye exams with a Plan Optometrist.       No charge (Plan Deductible doesn't apply)         Most physical, occupational, and speech therapy.       \$20 per visit (Plan Deductible doesn't apply)         Most physical, occupational, and speech therapy.       \$20 per visit (Plan Deductible doesn't apply)         Outpatient Services       You Pay         Outpatient Services       20% Coinsurance after Plan Deductible doesn't apply)         Most X-rays and laboratory tests.       No charge (Plan Deductible doesn't apply)         Most X-rays, screenings, and laboratory tests as described in the EOC.       No charge (Plan Deductible doesn't apply)         Mell, most CT, and PET scans.       20% Coinsurance up to a maximum of 5160 per procedure (Plan Deductible doesn't apply)         Most and, surgery, anesthesia, X-rays, laboratory tests, and drugs.       20% Coinsurance after Plan Deductible doesn't apply)         Moor and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.       20% Coinsurance after Plan Deductible doesn't apply)         Motulance Services.       You Pay					
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.       20% Coinsurance after Plan Deductible         Emergency Health Coverage       You Pay         Emergency Department visits.       20% 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       You Pay         Covered outpatient items in accord with our drug formulary guidelines:       \$150 per trip (Plan Deductible doesn't apply)         Most generic refills through our mail-order service.       \$10 for up to a 30-day supply (Plan Deductible doesn't apply)         Most brand-name items at a Plan Pharmacy.       \$30 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service.       \$30 for up to a 30-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service.       \$30 for up to a 30-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service.       \$30 for up to a 30-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service.       \$60 for up to a 30-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service.       \$20% Coinsuran	Most Physician Specialist Visits         Routine physical maintenance exams, including well-woman exams.         Well-child preventive exams (through age 23 months).         Family planning counseling and consultations.         Scheduled prenatal care exams.         Routine eye exams with a Plan Optometrist.         Urgent care consultations, evaluations, and treatment.         Most physical, occupational, and speech therapy.         Outpatient Services         Outpatient surgery and certain other outpatient procedures         Allergy antigens (including administration).         Most X-rays and laboratory tests.         Preventive X-rays, screenings, and laboratory tests as described in the EOC.		<ul> <li>\$20 per visit (Plan Det No charge (Plan Det \$20 per visit (Plan Det \$20 per visit (Plan Det \$20 per visit (Plan Det 20% Coinsurance aff No charge (Plan Det No charge (Plan Det \$10 per encounter (F DC</li></ul>	<ul> <li>\$20 per visit (Plan Deductible doesn't apply)</li> <li>No charge (Plan Deductible doesn't apply)</li> <li>\$20 per visit (Plan Deductible doesn't apply)</li> <li><b>You Pay</b></li> <li>20% Coinsurance after Plan Deductible</li> <li>No charge (Plan Deductible doesn't apply)</li> <li>\$10 per encounter (Plan Deductible doesn't apply)</li> <li>\$10 per encounter (Plan Deductible doesn't apply)</li> <li>No charge (Plan Deductible doesn't apply)</li> <li>20% Coinsurance up to a maximum of \$150 per procedure (Plan Deductible doesn't apply)</li> </ul>	
Emergency Health Coverage       You Pay         Emergency Department visits       20% 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       You Pay         Ambulance Services       \$150 per trip (Plan Deductible doesn't apply)         Prescription Drug Coverage       You Pay         Covered outpatient items in accord with our drug formulary guidelines:       \$10 for up to a 30-day supply (Plan Deductible doesn't apply)         Most generic refills through our mail-order service       \$20 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name items at a Plan Pharmacy       \$30 for up to a 30-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our	•			er Den Deductible	
Emergency Department visits.       20% 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.       \$150 per trip (Plan Deductible doesn't apply)         Prescription Drug Coverage       You Pay         Covered outpatient items in accord with our drug formulary guidelines:       \$10 for up to a 30-day supply (Plan Deductible doesn't apply)         Most generic refills through our mail-order service.       \$20 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name items at a Plan Pharmacy.       \$30 for up to a 30-day supply (Plan Deductible doesn't apply)         Most brand-name items at a Plan Pharmacy.       \$30 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service.       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service.       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most specialty items at a Plan Pharmacy.       \$20% Coinsurance (not to exceed \$250) for up to a 100-day supply (Plan Deductible doesn't apply)		Veu Deu	er 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       \$150 per trip (Plan Deductible doesn't apply)         Prescription Drug Coverage       You Pay         Covered outpatient items in accord with our drug formulary guidelines:       \$10 for up to a 30-day supply (Plan Deductible doesn't apply)         Most generic refills through our mail-order service.       \$20 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name items at a Plan Pharmacy       \$30 for up to a 30-day supply (Plan Deductible doesn't apply)         Most brand-name items at a Plan Pharmacy       \$30 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most specialty items at a Plan Pharmacy       \$20% Coinsurance (not to exceed \$250) for up to a			er Plan Deductible		
Ambulance Services	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)				
Prescription Drug Coverage       You Pay         Covered outpatient items in accord with our drug formulary guidelines:       Most generic items at a Plan Pharmacy	Ambulance Services			eductible doesn't apply)	
Most generic items at a Plan Pharmacy\$10 for up to a 30-day supply (Plan Deductible doesn't apply)Most generic refills through our mail-order service\$20 for up to a 100-day supply (Plan Deductible doesn't apply)Most brand-name items at a Plan Pharmacy\$30 for up to a 30-day supply (Plan Deductible doesn't apply)Most brand-name refills through our mail-order service\$60 for up to a 100-day supply (Plan Deductible doesn't apply)Most brand-name refills through our mail-order service\$60 for up to a 100-day supply (Plan Deductible doesn't apply)Most specialty items at a Plan Pharmacy\$20% Coinsurance (not to exceed \$250) for up to a					
Most brand-name items at a Plan Pharmacy       \$30 for up to a 30-day supply (Plan Deductible doesn't apply)         Most brand-name refills through our mail-order service       \$60 for up to a 100-day supply (Plan Deductible doesn't apply)         Most specialty items at a Plan Pharmacy       20% Coinsurance (not to exceed \$250) for up to a	Most generic items at a Plan Pharmacy		\$10 for up to a 30-da doesn't apply) \$20 for up to a 100-d		
doesn't apply) Most specialty items at a Plan Pharmacy for up to a 20% Coinsurance (not to exceed \$250) for up to a			\$30 for up to a 30-da doesn't apply)		
		doesn't apply) 20% Coinsurance (no	ot to exceed \$250) for up to a		

Proposed Benefit Summary	(continued)
Durable Medical Equipment (DME)	You Pay
DME items as described in the EOC	. 20% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	You Pay
Inpatient psychiatric hospitalization Individual outpatient mental health evaluation and treatment Group outpatient mental health treatment	. \$20 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	You Pay
Inpatient detoxification Individual outpatient substance use disorder evaluation and treatment Group outpatient substance use disorder treatment	. \$20 per visit (Plan Deductible doesn't apply)
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) Prosthetic and orthotic devices as described in the <i>EOC</i> Diagnosis and treatment of infertility and artificial insemination (such as outpatient	. No charge (Plan Deductible doesn't apply)
procedures or laboratory tests) as described in the EOC	. 50% Coinsurance (Plan Deductible doesn't apply)
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).