

Proposed Benefit Summary

Benefit Plan 8780

CS \$500 DED, \$20 OV, 10% 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.

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	\$3,000	\$3,000	\$6,000
Plan Deductible	\$500	\$500	\$1,000
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)
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)
Well-child preventive exams (through age 23 months).....	No charge (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)
Urgent care consultations, evaluations, and treatment.....	\$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 surgery and certain other outpatient procedures	10% Coinsurance after Plan Deductible
Allergy antigens (including administration).....	No charge (Plan Deductible doesn't apply)
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests.....	\$10 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the EOC.....	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans.....	10% Coinsurance up to a maximum of \$150 per procedure (Plan Deductible doesn't apply)

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	10% Coinsurance after Plan Deductible
---	---------------------------------------

Emergency Health Coverage

You Pay

Emergency Department visits.....	10% 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:

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 specialty items at a Plan Pharmacy.....	20% Coinsurance (not to exceed \$250) for up to a 30-day supply (Plan Deductible doesn't apply)

Proposed Benefit Summary*(continued)*

Durable Medical Equipment (DME)	You Pay
DME items as described in the <i>EOC</i>	20% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	10% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment.....	\$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment.....	\$10 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	You Pay
Inpatient detoxification.....	10% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment.....	\$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment.....	\$5 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)	10% Coinsurance (Plan Deductible doesn't apply)
Prosthetic and orthotic devices as described in the <i>EOC</i>	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 <i>EOC</i>	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services.....	Not covered
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).