### **Proposed Benefit Summary**

Benefit Plan 9931 CS \$25 OV, \$500 ADMIT, \$100 E R, \$15/\$35/30% RX

# **Principal Benefits for**

## Kaiser Permanente Traditional 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.

Amounts Per Accumulation Period (a Family of one Member)   Each Members in a Family of Members   Plan Out-of-Pocket Maximum   \$2,500   \$2,500   \$5,000   \$0,000   \$		Self-Only Coverage	Family Coverage	Family Coverage	
Plan Out-of-Pocket Maximum \$2,500 \$2,500 \$5,000 Plan Deductible None None None None None None None Non	Amounts Per Accumulation Period		Each Member in a Family of	Entire Family of two or more	
Plan Deductible   None   Non		, , , , , , , , , , , , , , , , , , , ,			
Drug Deductible   None   None   None   None   Professional Services (Plan Provider office visits)   You Pay					
Professional Services (Plan Provider office visits)  Most Primary Care Visits and most Non-Physician Specialist Visits.  S25 per visit  Nost Physician Specialist Visits.  Routine physical maintenance exams, including well-woman exams.  No charge  Well-child preventive exams (through age 23 months).  No charge  Family planning counseling and consultations.  No charge  Scheduled prenatal care exams.  No charge  Routine eye exams with a Plan Optometrist.  Urgent care consultations, evaluations, and treatment.  S25 per visit  Most physical, occupational, and speech therapy.  S25 per visit  Most physical, occupational, and speech therapy.  S250 per procedure  Allergy antigens (including administration).  No charge  Most immunizations (including the vaccine).  Most synamications (including the vaccine).  Most and synamications (including the vaccine).  Most Arays and laboratory tests as described in the EOC.  No charge  Most X-rays, screenings, and laboratory tests, and drugs.  \$50 per procedure  Hospitalization Services  You Pay  Emergency Department visits.  \$100 per visit  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 (see "Hospitalization Services" for inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share instead of the E					
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Allergy antigens (including administration)	Outpatient Services		You Pay		
Most immunizations (including the vaccine)	Outpatient surgery and certain other outpa	tient procedures	\$250 per procedure		
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Durable Medical Equipment (DME)  DME items as described in the EOC					
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Individual outpatient mental health evaluation and treatment			-		
Group outpatient mental health treatment \$12 per visit  Substance Use Disorder Treatment You Pay					
Substance Use Disorder Treatment You Pay					
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Proposed Benefit Summary		(continued)
Substance Use Disorder Treatment	You Pay	
Individual outpatient substance use disorder evaluation and treatment	\$25 per visit \$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 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).