Proposed Benefit Summary

Benefit Plan 12188 CS \$2,800 DED, \$30 OV, 30% IP , \$15/\$30/20% RX

Principal Benefits for

Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO (1/1/22—12/31/22)

"Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the *EOC*.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

Amounts Per Accumulation Period

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.

Family Coverage

Each Member in a Family of

Family Coverage

Entire Family of two or more

Note: The Plan Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.

Self-Only Coverage

(a Family of one Member)

| Plan Out-of-Pocket Maximum \$5,250 \$5,250 \$10,500 Plan Deductible \$2,800 \$2,800 \$5,600 Drug Deductible Not applicable Not applicable Not applicable Not applicable Not applicable Professional Services (Plan Provider office visits) You Pay | Amounts i et Accumulation i eriou | (a Family of one Member) | | citibet in a raining of | Little Latility of two of more |
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| Drug Deductible Not applicable Not applicable Not applicable Not applicable | | +-, | | T - 1 | |
| Professional Services (Plan Provider office visits) Most Primary Care Visits and most Non-Physician Specialist Visits \$30 per visit after Plan Deductible Most Physician Specialist Visits S30 per visit after Plan Deductible 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 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) Scheduled prenatal care exams. 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. Urgent care consultations, evaluations, and treatment. \$30 per visit after Plan Deductible Most physical, occupational, and speech therapy. \$30 per visit after Plan Deductible Outpatient surgery and certain other outpatient procedures You Pay Outpatient surgery and certain other outpatient procedures Allergy antigens (including administration). \$5 per visit after Plan Deductible Most immunizations (including the vaccine). Not charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans. S10 per encounter after Plan Deductible 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. S10 per encounter after Plan Deductible Preventive X-rays, anesthesia, X-rays, laboratory tests, and drugs. 30% Coinsurance after Plan Deductible Most perfect plan Deductible Preventive X-rays, anesthesia, X-rays, laboratory tests, and drugs. 30% Coinsurance after Plan Deductible Preventive X-pay and the pla | | | | | |
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| Most immunizations (including the vaccine) | | | | | |
| Preventive X-rays, screenings, and laboratory tests as described in the EOC | | | | No charge (Plan Deductible doesn't apply) \$10 per encounter after Plan Deductible | |
| MRI, most CT, and PET scans | Most X-rays and laboratory tests | | | | |
| Hospitalization Services Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | | | | | |
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | MRI, most CT, and PET scans | | | | |
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | | | | • | Deductible |
| Emergency Health Coverage Emergency Department visits | • | | | | |
| Emergency Department visits | Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | | | | |
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| Proposed Benefit Summary | (continued) | | |
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| Prescription Drug Coverage | You Pay | | |
| Most specialty items at a Plan Pharmacy | 20% Coinsurance (not to exceed \$250) for up to a 30-day supply after Plan Deductible | | |
| Durable Medical Equipment (DME) | You Pay | | |
| DME items as described in the EOC | 20% Coinsurance after Plan Deductible | | |
| Mental Health Services | You Pay | | |
| Inpatient psychiatric hospitalization Individual outpatient mental health evaluation and treatment Group outpatient mental health treatment | \$30 per visit after Plan Deductible | | |
| Substance Use Disorder Treatment | You Pay | | |
| Inpatient detoxification Individual outpatient substance use disorder evaluation and treatment Group outpatient substance use disorder treatment | \$30 per visit after Plan Deductible | | |
| Home Health Services | You Pay | | |
| Home health care (up to 100 visits per Accumulation Period) | No charge after Plan Deductible | | |
| Other | You Pay | | |
| Skilled nursing facility care (up to 100 days per benefit period) Prosthetic and orthotic devices as described in the EOC Diagnosis and treatment of infertility and artificial insemination Assisted reproductive technology ("ART") Services Hospice care | No charge after Plan Deductible Not covered Not covered | | |

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).