

Proposed Benefit Summary**Benefit Plan 10681****\$25 OV, \$500 ADMIT, \$100 ER, \$15/\$35/30% RX, OPT****Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/23—12/31/23)****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	\$1,500	\$1,500	\$3,000
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.....	\$25 per visit
Most Physician Specialist Visits.....	\$25 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	\$25 per visit
Most physical, occupational, and speech therapy	\$25 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	\$100 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	\$10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the EOC.....	No charge
MRI, most CT, and PET scans	\$50 per procedure

Hospitalization Services**You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	\$500 per admission
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Emergency Health Coverage**You Pay**

Emergency Department visits.....	\$100 per visit
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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	\$100 per trip
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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	\$35 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	\$70 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	30% Coinsurance (not to exceed \$250) for up to a 30-day supply

Proposed Benefit Summary*(continued)*

Durable Medical Equipment (DME)	You Pay
DME items as described in the <i>EOC</i>	20% Coinsurance
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	\$500 per admission
Individual outpatient mental health evaluation and treatment	\$25 per visit
Group outpatient mental health treatment	\$12 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$500 per admission
Individual outpatient substance use disorder evaluation and treatment	\$25 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
Eyeglasses or contact lenses:	
Eyeglass frame every 24 months	Amount in excess of \$150 Allowance
Regular eyeglass lenses every 12 months	No charge
Contact lenses every 12 months	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i>	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*.