

## Proposed Benefit Summary

### Benefit Plan 14829

\$3,000 DED, \$0 OV, \$0 IP, \$0/\$0/\$0 RX

## Principal Benefits for

### Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO (1/1/23—12/31/23)

"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 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.

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 deductibles 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	\$3,000	\$3,000	\$6,000
Drug Deductible	Not applicable	Not applicable	Not applicable

#### Plan Provider Office Visits

Most Primary Care Visits and most Non-Physician Specialist Visits.....  
Most Physician Specialist Visits.....  
Routine physical maintenance exams, including well-woman exams ....  
Well-child preventive exams (through age 23 months) .....  
Scheduled prenatal care exams .....  
Routine eye exams with a Plan Optometrist.....  
Urgent care consultations, evaluations, and treatment .....  
Most physical, occupational, and speech therapy .....

#### You Pay

No charge after Plan Deductible  
No charge after Plan Deductible  
No charge (Plan Deductible doesn't apply)  
No charge (Plan Deductible doesn't apply)  
No charge (Plan Deductible doesn't apply)  
No charge (Plan Deductible doesn't apply)  
No charge after Plan Deductible  
No charge after Plan Deductible

#### Telehealth Visits

Primary Care Visits and Non-Physician Specialist Visits by interactive  
video .....  
Physician Specialist Visits by interactive video .....  
Primary Care Visits and Non-Physician Specialist Visits by telephone..  
Physician Specialist Visits by telephone.....

#### You Pay

No charge after Plan Deductible  
No charge after Plan Deductible  
No charge after Plan Deductible  
No charge after Plan Deductible

#### Outpatient Services

Outpatient surgery and certain other outpatient procedures .....  
Most immunizations (including the vaccine).....  
Most X-rays and laboratory tests .....  
Preventive X-rays, screenings, and laboratory tests as described in  
the EOC.....

#### You Pay

No charge after Plan Deductible  
No charge (Plan Deductible doesn't apply)  
No charge after Plan Deductible  
No charge (Plan Deductible doesn't apply)

#### Hospitalization Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and  
drugs.....

#### You Pay

No charge after Plan Deductible

#### Emergency Health Coverage

Emergency Department visits.....

#### You Pay

No charge 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

Ambulance Services .....

#### You Pay

No charge after Plan Deductible

#### Prescription Drug Coverage

Covered outpatient items in accord with our drug formulary guidelines:  
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-  
order service .....

#### You Pay

No charge for up to a 100-day supply after Plan  
Deductible

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**Proposed Benefit Summary***(continued)***Prescription Drug Coverage****You Pay**

Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service .....	No charge for up to a 100-day supply after Plan Deductible
Most specialty items (Tier 4) at a Plan Pharmacy .....	No charge for up to a 30-day supply after Plan Deductible

**Durable Medical Equipment (DME)****You Pay**

Base DME items as described in the <i>EOC</i> .....	No charge after Plan Deductible
Supplemental DME items up to a \$2,500 benefit limit per Accumulation Period as described in the <i>EOC</i> .....	No charge after Plan Deductible

**Mental Health Services****You Pay**

Inpatient psychiatric hospitalization .....	No charge after Plan Deductible
Individual outpatient mental health evaluation and treatment .....	No charge after Plan Deductible
Group outpatient mental health treatment .....	No charge after Plan Deductible

**Substance Use Disorder Treatment****You Pay**

Inpatient detoxification .....	No charge after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment .....	No charge after Plan Deductible
Group outpatient substance use disorder treatment .....	No charge after Plan Deductible

**Home Health Services****You Pay**

Home health care (up to 100 visits per Accumulation Period) .....	No charge after Plan Deductible
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**Other****You Pay**

Skilled nursing facility care (up to 100 days per benefit period) .....	No charge after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i> .....	No charge after Plan Deductible
Diagnosis and treatment of infertility and artificial insemination .....	Not covered
Assisted reproductive technology ("ART") Services .....	Not covered
Hospice care .....	No charge after Plan Deductible

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*.