Participating Provider Tier(**)** Non-Participating Provider Tier(**)* Non-Participating Participating Provider Tier(**)* Non-Participating P		Kaiser Permanente Point-of-Service Plan 13894 NCR / 13895 SCR			
The Accumulation Period for this Plan is Calendar Year Maximum benefit while insured Deductible per accumulation period ⁽¹⁾ Out-of-Pocket Maximum per accumulation period ⁽²⁾ From and board, including obstetrics Imaging, including Arrays and lab tests Physician office visits Sencitled preventive screening services Routine adult physical exams Well-child preventive care visits Family planning visits Pamily planning visits Sanctine adult physical exams Well-child preventive care visits Family planning X-rays and lab tests No charge No	2023 Benefit Summary	Permanente Plan			
Deductible per accumulation period(1)					
Deductible per accumulation period ⁽¹⁾ None S1,500 Individual S3,000 Family S6,000 Family S9,000 F	The Accumulation	Period for this Plan is	Calendar Year		
None \$1,500 Individual \$3,000 Family \$6,000 Family \$6,	Maximum benefit while insured		Unlimited		
Out-of-Pocket Maximum per accumulation period(²) \$2,500 Individual \$4,500 Individual \$9,000 Family \$6,000 Family \$18,000 Family \$9,000 Individual \$9,000 Family \$9,000 Individual \$9,000 Family \$9,000 Individual \$9,000 Family \$9,000 Individual \$9,000 Family \$9,000 Family \$9,000 Family \$9,000 Family \$9,000 Family \$1,000 Copayment per admission, then Per adm		Member pays			
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Period(²)			\$3,000 Family	\$6,000 Family	
Hospital care	Out-of-Pocket Maximum per accumulation	\$2,500 Individual	\$4,500 Individual	\$9,000 Individual	
Room and board, including obstetrics Imaging, including X-rays and lab tests Physician, surgeon, and surgical services Nursing care, anesthesia, and medications Birth Services(6) Outpatient care Physician office visits Specialty Care Telehealth visits(8) Preventive screening services No charge Well-child preventive care visits Family planning visits Scheduled prenatal and first post-partum visits(5) Outpatient surgery Imaging, including X-rays and lab tests Hearing exams Physical, occupational, and speech therapy visits Health education Emergency Care (Copayment waived if admitted directly to hospital) Emergency Ambulance Service Medically Necessary Non-emergency Per admission, then No charge 20% 50% 50% 50% Solv 20% 50% 50% 50% 50% 50% 50% 50% 50% 50% 5	period ⁽²⁾	\$5,000 Family	\$9,000 Family	\$18,000 Family	
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Birth Services ⁽⁶⁾ Outpatient care Physician office visits Specialty Care Telehealth visits ⁽⁸⁾ Preventive screening services Routine adult physical exams Well-child preventive care visits Family planning visits Scheduled prenatal and first post-partum visits ⁽⁵⁾ Outpatient surgery Imaging, including X-rays and lab tests Hearing exams Health education Emergency Care (Copayment waived if admitted directly to hospital) Physical office visits San Copayment 20% Sove 50% No charge No charge No charge(3)(4) Not covered No charge(3)(4) Not covered No charge(3)(4) No charge(3)(6) No charge(3) Sov(3) Sov(3) Sov(3) No charge No charge(3) Sov(3) Sov(3) Sov(3) Sov(3) Sov(4) No charge No charge(3) Sov(3) Sov(3) Sov(4) Sov(4) Sov(5) Sov(6) Sov(6) Sov(7) Sov(8) Sov(8) Sov(9) Sov(9) Sov(9) Sov(9) Sov(9) Sov(9) Sov(1) S		_			
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Physician office visits Specialty Care Telehealth visits(8) Preventive screening services Routine adult physical exams Well-child preventive care visits Family planning visits Scheduled prenatal and first post-partum visits(5) Outpatient surgery Imaging, including X-rays and lab tests Hearing exams Health education Physical, occupational, and speech therapy visits Health education Physical of the first post-parture (Copayment waived if admitted directly to hospital) Physician office visits Sand Copayment No charge No charge No charge(3) No charge(3) No charge(3) No charge(3) No charge(3) No charge(3) Some per procedure Sums No charge No charge(3) Some per procedure Sums No charge Covered under the HMO Tier Only Covered under the HMO Tier Only Functional admitted directly to hospital) Covered under the HMO Tier, subject to a \$150 Copayment, regardless of facility/hospital accessed(7) Covered under the HMO Tier, subject to a \$150 charge Covered under the HMO Tier, subject to a \$150 charge	Birth Services ⁽⁶⁾	No charge	20%	50%	
Specialty Care Telehealth visits(8) Preventive screening services Routine adult physical exams Well-child preventive care visits Family planning visits Scheduled prenatal and first post-partum visits(5) Outpatient surgery Imaging, including X-rays and lab tests Hearing exams Health education Physical, occupational, and speech therapy visits Health education Emergency Care (Copayment waived if admitted directly to hospital) Specially Care No charge No charge No charge(3) No charge(3) No charge(3) No charge(3) No charge(3) No charge(3) So% per procedure 20% per	-				
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Imaging, including X-rays and lab tests Hearing exams Physical, occupational, and speech therapy visits Health education Emergency Care (Copayment waived if admitted directly to hospital) Per procedure \$10 Copayment No charge Covered under the HMO Tier Only \$30 Copayment No charge Covered under the HMO Tier Only Covered under the HMO Tier Only Covered under the HMO Tier Only Covered under the HMO Tier, subject to a \$150 Copayment, regardless of facility/hospital accessed Covered under the HMO Tier, subject to a \$150 charge Covered under the HMO Tier, subject to a \$150 charge	visits ⁽⁵⁾	_	No charge ⁽³⁾	50% ⁽³⁾	
Hearing exams No charge Covered under the HMO Tier Only Physical, occupational, and speech therapy visits Health education The Halth education Solvation and speech therapy visits Health education The Halth education No charge Covered under the HMO Tier Only Covered under the HMO Tier Only Emergency Care (Copayment waived if admitted directly to hospital) Covered under the HMO Tier, subject to a \$150 Copayment, regardless of facility/hospital accessed(7) Covered under the HMO Tier, subject to a \$150 charge Covered under the HMO Tier, subject to a \$150 charge	Outpatient surgery		20% per procedure	50% per procedure	
Physical, occupational, and speech therapy visits Health education Emergency Care (Copayment waived if admitted directly to hospital) Emergency Ambulance Service Medically Necessary Non-emergency Sao Copayment No charge Sao Copayment And Tier Only Covered under the HMO Tier Only Covered under the HMO Tier, subject to a \$150 Copayment, regardless of facility/hospital accessed(7) Covered under the HMO Tier, subject to a \$150 charge					
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Emergency Care (Copayment waived if admitted directly to hospital) Covered under the HMO Tier, subject to a \$150 Copayment, regardless of facility/hospital accessed(7) Emergency Ambulance Service Medically Necessary Non-emergency Medically Non-emergency HMO Tier Only Covered under the HMO Tier, subject to a \$150 Copayment, regardless of facility/hospital accessed(7)		\$30 Copayment	20%	50%	
(Copayment waived if admitted directly to hospital) Covered under the HMO Tier, subject to a \$150 Copayment, regardless of facility/hospital accessed ⁽⁷⁾ Emergency Ambulance Service Medically Necessary Non-emergency Covered under the HMO Tier, subject to a \$150 charge	Health education	No charge			
Medically Necessary Non-emergency	(Copayment waived if admitted directly to				
	Emergency Ambulance Service	Covered under t	he HMO Tier, subject	to a \$150 charge	
7.22		\$150	50%	50%	
Urgent Care \$30 Copayment 20% 50%	Urgent Care				

	Kaiser Permanente Point-of-Service Plan 13894 NCR / 13895 SCR			
2023 Benefit Summary	HMO Tier (Kaiser Permanente Plan Providers)	Participating Provider Tier (19) *	Non-Participating Provider Tier*	
		Precertification is required for certain services [†]		
		Member pays		
Prescriptions ⁽⁹⁾	Kaiser Permanente	MedImpact	Non-Participating	
(30-day supply)	Pharmacies	Pharmacies ⁽¹⁰⁾⁽²⁰⁾	Pharmacies	
Generic preferred tier	\$10 Copayment	\$20 Copayment	Not covered	
Generic non-preferred tier	\$10 Copayment ⁽¹⁸⁾	\$50 Copayment	Not covered	
Brand preferred tier	\$30 Copayment	\$40 Copayment	Not covered	
Brand non-preferred tier	\$30 Copayment (18)	\$50 Copayment	Not covered	
Specialty tier ⁽¹⁷⁾	20% with \$250 per prescription maximum	30% with \$250 per prescription maximum	Not covered	
Mail-order Prescriptions				
Generic drugs (maximum 100-day supply)	\$20 Copayment	Most prescriptions from Participating/Non-Participating Providers		
Brand preferred drugs (maximum 100- day supply)	\$60 Copayment	Pharmacies and re order. Mail-order se	aiser Permanente efilled through mail- rvice is not available t Pharmacies.	
Mental health services				
Inpatient hospitalization	\$500 Copayment	\$500 Copayment	\$1,000 Copayment	
	per admission	per admission, then 20%	per admission, then 50%	
Outpatient individual therapy visits	\$30 Copayment	20%	50%	
Outpatient group therapy visits	\$15 Copayment	20%	50%	
Substance use disorder treatment				
Inpatient hospitalization	\$500 Copayment	\$500 Copayment	\$1,000 Copayment	
	per admission	per admission, then 20%	per admission, then 50%	
Outpatient individual therapy visits	\$30 Copayment	20%	50%	
Outpatient group therapy visits	\$5 Copayment	20%	50%	
Durable medical equipment	30%	30% ⁽¹⁴⁾	50% ⁽¹⁴⁾	
Diabetic Equipment and Supplies ⁽¹⁵⁾	30%	30%	30%	
Prosthetics, orthotics, and special footwear ⁽¹⁶⁾	No charge	20%	50%	
Additional benefits				
Skilled nursing facility care ⁽²¹⁾	\$500 Copayment (100-day limit per	\$500 Copayment per admission,	\$1,000 Copayment per admission, then	
	benefit period)	then 20% ⁽¹¹⁾	50%(11)	
Home health care (100-day limit per accumulation period) ⁽²¹⁾	No charge	20%(3)(12)	20%(3)(12)	
Hospice care	No charge	20%	50%	
Fertility services	\$30 Copayment	20%(3)(13)	50%(3)(13)	

Note: These benefits are subject to regulatory approval.

This chart only describes a summary of the benefits. For a complete understanding of benefits, please read the Kaiser Permanente Point-of-Service Disclosure Form and Evidence of Coverage and the Kaiser Permanente Insurance Company *Certificate of Insurance*. The Disclosure Form, Evidence of Coverage, and the *Certificate of Insurance* together contain a complete explanation of benefits, exclusions, and limitations. The information provided in this chart is not intended for use as a Summary Plan Description, the Disclosure Form, Evidence of Coverage, or the *Certificate of Insurance*.

Footnotes

- (1) Deductible amounts are separate for services provided by Participating Providers and Non-Participating Providers. This plan carries an embedded Deductible and Out-of-Pocket Maximum. Benefits become payable for each family member after their individual annual Deductible is met, or when the family Deductible is satisfied. Deductibles contribute towards satisfying the Out-of-Pocket Maximum. A family member can meet the individual annual Out-of-Pocket Maximum before the family Out-of-Pocket Maximum is satisfied.
- (2) Covered Charges applied to satisfy the Out-of-Pocket Maximum at the Participating Provider Tier will not apply toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider Tier. Likewise, Covered Charges applied to satisfy the Out-of-Pocket Maximum at the Non-Participating Provider Tier will not apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider Tier. For a complete understanding of the Out-of-Pocket Maximum, please refer to your Certificate of Insurance.
- (3) Exempt from Deductible.
- (4) Routine adult physical exams are limited to one exam every 12 months.
- (5) Routine prenatal care office visits are covered as required under the Patient Protection Affordable Care Act (PPACA). This includes the initial and subsequent histories, physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis.
- (6) Birth Services including delivery and inpatient care for mother and baby are covered under your inpatient services benefit. For a complete understanding of Birth Services, please see your *Certificate of Insurance*.
- (7) Emergency medical services are covered under the HMO Tier. Non-emergency medical services received in an emergency care setting that are not covered under the HMO Tier may be eligible for coverage under the Participating Provider or Non-Participating Provider Tiers.
- (8) Telehealth care is provided where applicable and available via communication methods such as telephone, video, or email. Cost shares vary depending on the type of service provided and are equivalent to an in-person visit specific to that service except when using the HMO tier where the cost share is \$0 (no charge).
- (9) MedImpact Pharmacy Copayment and Coinsurance are not subject to, nor do they contribute toward satisfaction of the Deductible. However, they do contribute toward the satisfaction of the Out-of-Pocket Maximum. Select prescription drugs are excluded from coverage.
- (10) Member is responsible for paying the brand name Copayment plus the difference in cost between the generic drug and the brand name drug when patient requests brand name drug and a generic version is prescribed by the physician.
- (11) Skilled Nursing Facility care is limited to a maximum of 60 days per benefit period combined for services provided by Participating Providers and Non-Participating Providers.
- (12) Home Health Care is limited to a maximum of 100 visits per accumulation period combined for services provided by Participating Providers and Non-Participating Providers.
- (13) Benefits payable for treatment of infertility are limited to \$1,000 per accumulation period combined for services provided by Participating Providers and Non-Participating Providers. In vitro fertilization is not covered. Benefits payable for diagnosis of infertility will be covered on the same basis as a sickness.

- Covered Charges for infertility services do not accumulate towards satisfaction of the Out-of-Pocket Maximum.
- (14) Certain Durable Medical Equipment is limited to a maximum of \$2,000 per accumulation period combined for services provided by Participating Providers and Non-Participating Providers. Certain Durable Medical Equipment is not subject to the Deductible nor contributes to the Out-of-Pocket Maximum.
- (15) Some diabetic equipment and supplies such as: infusion set and syringe with needle for external insulin pumps, testing strips, lancets, skin barrier, adhesive remover wipes and transparent film are payable based on actual billed charges and are not subject to the DME annual maximum of \$2,000 per accumulation period.
- (16) Most items are not covered.
- (17) Specialty drugs are not eligible for mail order incentive and may not be available under the mail order service.
- (18) Non-preferred drugs are covered at a Kaiser Permanente pharmacy only when prescribed by Kaiser Permanente Plan Providers through exception process or when related to emergency care, out-of-area urgent care, or an authorized referral.
- (19) Online directories of Participating Providers available to you can be found by visiting kp.org/kpic/pos.
- (20) An online directory of Pharmacies available to you can be found by visiting kp.org/pharmacylocator/pos.
- (21) The visit maximum does not apply to medically necessary treatment of Mental Health and Substance Use Disorder.

†Precertification of services provided by Participating Providers and Non-Participating Providers

Precertification is required for all hospital confinements, including preadmission testing, inpatient care at a Skilled Nursing Facility, or other licensed, freestanding facilities, such as Hospice Care, Home Health Care, or care at a rehabilitation facility, or selected outpatient procedures. Failure to obtain precertification will result in a penalty of \$500 per occurrence for covered charges incurred in connection with these services. This penalty will not count toward the satisfaction of any Deductibles or Out-of-Pocket Maximums. For a complete understanding of precertification requirements, please refer to your *Certificate of Insurance*.

*Payments Based on Maximum Allowable Charge for Covered Services

Maximum Allowable charge means the lesser of: the Usual, Customary, and Reasonable Charges or the Negotiated Rate or the Actual Billed Charges. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service.

The HMO Tier of the Point-of-Service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) while the Participating Provider and Non-Participating Provider Tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.