Proposed Benefit Summary

Benefit Plan 13860 \$5,000 DED, \$50 OV, 30% IP, \$15/\$50/30% RX

Principal Benefits for Kaiser Permanente Deductible HMO Plan (1/1/24—12/31/24)

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 (as Family of one Member) (as Family of one Member) Each Member in a Family of two or more Members Entire Family of two or more Members Plan Out-of-Pocket Maximum \$7,000 \$14,000 Plan Deductible \$5,000 \$5,000 \$14,000 Drug Deductible None None None Plan Provider Office Visits You Pay S50 per visit after Plan Deductible* S50 per visit after Plan Deductible Most Primary Care Visits and most Non-Physician Specialist Visits \$50 per visit after Plan Deductible doesn't apply) Well-child preventive exams (through age 23 months) No charge (Plan Deductible doesn't apply) Schuled prenatal care exams, nou of treatment \$50 per visit after Plan Deductible Most physical, occupational, and speech therapy \$50 per visit after Plan Deductible The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. Telebeath Visits You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) No starge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Physician Speciali			Family Coverage	Family Coverage	
Plan Out-of-Pocket Maximum \$7,000 \$7,000 \$10,000 Plan Deductible \$5,000 \$10,000 Drug Deductible None None Drug Deductible None None Most Physician Specialist Visits \$50 per visit after Plan Deductible* Most Physician Specialist Visits \$50 per visit after Plan Deductible doesn't apply) Well-child preventive exams (through age 23 months) No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams. No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$50 per visit after Plan Deductible "The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. Telehealth Visits You frast three visits by interactive Video No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't appl	Amounts Per Accumulation Period	Self-Only Coverage			
Plan Deductible \$5.000 \$5.000 \$10,000 Drug Deductible None None None None Plan Provider Office Visits None None None None Most Privacian Specialist Visits S50 per visit after Plan Deductible S50 per visit after Plan Deductible S50 per visit after Plan Deductible Most Privacian Specialist Visits S50 per visit after Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Well-child preventive exams (through age 23 months) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan optometrist. No charge (Plan Deductible doesn't apply) No charge (Plan Deductible Telehealth Visits Primary Care Visits and Non-Physician Specialist Visits by Interactive video No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Outpatient Services 30% Coinsurance after P		(a Family of one Member)	of two or more Members	more Members	
Drug Deductible None None None Plan Provider Office Visits Most Primary Care Visits and most Non-Physician Specialist Visits \$50 per visit after Plan Deductible* Most Primary Care Visits and most Non-Physician Specialist Visits \$50 per visit after Plan Deductible doesn't apply) Well-child preventive exams (through age 23 months) No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams No charge (Plan Deductible doesn't apply) Woll-child preventive exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Urgent care consultations, evaluations, and treatment \$50 per visit after Plan Deductible* Most physical, occupational, and speech therapy \$50 per visit after Plan Deductible* Primary Care Visits and Non-Physician Specialist Visits by interactive You Pay Primary Care Visits and Non-Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Outpatient surgery and certain other outpatient procedures 30% Coinsurance after Plan Deductible Most X-rays, screenings, and laboratory tests and decribe doesn't apply) You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. 30% Coinsurance					
Plan Provider Office Visits You Pay Most Physician Specialist Visits \$50 per visit after Plan Deductible* Most Physician Specialist Visits \$50 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 prentatic are exams. No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Most Physical, occupational, and speech therapy \$50 per visit after Plan Deductible* *The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Outpatient Surgery and certain other outpatient procedures 30% Coinsurance after Plan Deductible				\$10,000	
Most Primary Care Visits and most Non-Physician Specialist Visits \$50 per visit after Plan Deductible Most Physician Specialist Visits \$50 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) Routine eye exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Work of a specialist Visits and non-Repeace therapy \$50 per visit after Plan Deductible *The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) No starge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Priscian Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Nota farge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply	Drug Deductible	None	None	None	
Most Physician Specialist Visits \$50 per visit after Plan Deductible Routine physical maintenance exams, including well-woman 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) Urgent care consultations, evaluations, and treatment \$50 per visit after Plan Deductible doesn't apply) Woel child preventive exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) Woel child preventive exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) Urgent care consultations, evaluations, and treatment \$50 per visit after Plan Deductible doesn't apply) Primery Care visits and Non-Physician Specialist Visits by interactive video You Pay Primary Care Visits and Non-Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Outpatient Services 30% Coinsurance aft	Plan Provider Office Visits You Pay				
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) Routine eye exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$50 per visit after Plan Deductible* "The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the <i>EOC</i> . Telehealth Visits You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physical specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physical specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physical specialist Visits by telephone No charge (Plan Deductible doesn't apply) Physical specialist Visits by telephone No charge (Plan Deductible doesn't apply) Notarge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most mumuizations (including the vaccine	Most Primary Care Visits and most Nor	n-Physician Specialist Visits.	\$50 per visit after Plan	\$50 per visit after Plan Deductible*	
Well-child preventive exams (through age 23 months) 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. No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy \$50 per visit after Plan Deductible* *The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient Services You Pay Most Arays and laboratory tests adescribed in the EOC. No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Most infruenziation Services You Pay Most and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. 30% Coinsurance after Plan Deductible Emergency Department	Most Physician Specialist Visits		. \$50 per visit after Plan Deductible		
Scheduled prenatal care exams No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Wost physical, occupational, and speech therapy. \$50 per visit after Plan Deductible* *The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. You Pay Telehealth Visits You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Outpatient surgery and certain other outpatient procedures. 30% Coinsurance after Plan Deductible Most X-rays, screenings, and laboratory tests as described in the EOC. You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. 30% Coinsurance after Plan Deductible Root range (Plan Deductible doesn't apply) You Pay Room and board, surgery, anesthesia, X-rays, laboratory					
Routine eye exams with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Urgent care consultations, evaluations, and treatment. \$50 per visit after Plan Deductible* *Sto per visit after Plan Deductible \$50 per visit after Plan Deductible *The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Outpatient surgery and certain other outpatient procedures 30% Coinsurance after Plan Deductible Most X-rays, and laboratory tests 30% Coinsurance after Plan Deductible No charge (Plan Deductible doesn't apply) You Pay Most Arrays, and laboratory tests, and drugs 30% Coinsurance after Plan Deductible No charge (Plan Deductible doesn't apply) 30% Coinsurance after Plan Deductible Most appet perventive X-rays, screenings, and laboratory tests, and drugs 30% Coinsurance after Plan Deductible					
Urgent care consultations, evaluations, and treatment \$50 per visit after Plan Deductible* Most physical, occupational, and speech therapy \$50 per visit after Plan Deductible* *The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by itelephone. No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient surgery and certain other outpatient procedures. 30% Coinsurance after Plan Deductible Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in the EOC. No charge (Plan Deductible doesn't apply) Hospitalization Services 30% Coinsurance after Plan Deductible Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. 30% Coinsurance after Plan Deductible					
Most physical, occupational, and speech therapy \$50 per visit after Plan Deductible "The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. You Pay Telehealth Visits You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient Services 30% Coinsurance after Plan Deductible Preventive X-rays, and laboratory tests. 30% Coinsurance after Plan Deductible No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most rays, and laboratory tests. 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests, and drugs. 30% Coinsurance after Plan Deductible Most generic (Tier Y) endem to visits. 30% Coinsurance after Plan Deductible Not charge (Pl					
*The Plain Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC. Telehealth Visits Primary Care Visits and Non-Physician Specialist Visits by interactive video Primary Care Visits and Non-Physician Specialist Visits by telephone. Primary Care Visits and Non-Physician Specialist Visits by telephone. Primary Care Visits and Non-Physician Specialist Visits by telephone. Primary Care Visits and Non-Physician Specialist Visits by telephone. Primary Care Visits and Non-Physician Specialist Visits by telephone. Primary Care Visits and Non-Physician Specialist Visits by telephone. Primary Care Visits and Non-Physician Specialist Visits by telephone. Post insurance after Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests as described in the EOC. Host and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. Berregency Health Coverage Emergency Department visits. Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share (see "Hospitalization Services" for inpatient Cost Share (see "Hospitalization Services" for inpatient Cost Share (See "Hospitalization Services" or inpatient Cost Share (See "Hospitalization Services" for inpatient Cost Share (See "Hospitalization Services for inpatient Cost Share (See "Hospitalization Services" for inpatient Cost Share (See "Hospitalization Services" for					
substance use disorder treatment Services as described in the EOC. Telehealth Visits You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient surgery and certain other outpatient procedures. 30% Coinsurance after Plan Deductible Most X-rays and laboratory tests. 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in the EOC. No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. 30% Coinsurance after Plan Deductible Image: You Pay Emergency Health Coverage You Pay Emergency Department visits. 30% Coinsurance after Plan Deductible Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cos					
Telehealth Visits You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Priscian Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient surgery and certain other outpatient procedures 30% Coinsurance after Plan Deductible Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most Z-rays and laboratory tests 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in the EOC No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. 30% Coinsurance after Plan Deductible Emergency Health Coverage You Pay Emergency Department visits. 30% Coinsurance after Plan Deductible Note: If you are admitted directly to the hospital as an inpatient f					
Primary Care Visits and Non-Physician Specialist Visits by interactive No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Outpatient surgery and certain other outpatient procedures 30% Coinsurance after Plan Deductible Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in the EOC No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs 30% Coinsurance after Plan Deductible Emergency Health Coverage You Pay Emergency Department visits. 30% Coinsurance 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					
videoNo charge (Plan Deductible doesn't apply)Physician Specialist Visits by interactive videoNo charge (Plan Deductible doesn't apply)Primary Care Visits and Non-Physician Specialist Visits by telephone.No charge (Plan Deductible doesn't apply)Physician Specialist Visits by telephone.No charge (Plan Deductible doesn't apply)Outpatient ServicesYou PayOutpatient surgery and certain other outpatient procedures30% Coinsurance after Plan DeductibleMost X-rays and laboratory testsNo charge (Plan Deductible doesn't apply)Most X-rays and laboratory tests30% Coinsurance after Plan DeductiblePreventive X-rays, screenings, and laboratory tests as described in the EOCNo charge (Plan Deductible doesn't apply)Hospitalization ServicesYou PayRoom and board, surgery, anesthesia, X-rays, laboratory tests, and drugs30% Coinsurance after Plan DeductibleEmergency Department visits30% Coinsurance after Plan DeductibleNote: 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 "HospitalizationServices, you will pay the inpatient Cost Share)Ambulance ServicesYou PayCovered outpatient items in accord with our drug formulary guidelines: Most generic (Tier 1) at a Plan PharmacyYou PayStore outpatient items in accord with our drug formulary guidelines: Most generic (Tier 1) refilts through our mail-order service\$15 for up to a 30-day supply after Plan DeductibleYou PayStore outpatient items in accord with our drug formulary guidelines: Most generic			You Pay		
Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient surgery and certain other outpatient procedures 30% Coinsurance after Plan Deductible Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests. 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in the EOC. No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. 30% Coinsurance after Plan Deductible Emergency Health Coverage You Pay Emergency Department visits. 30% Coinsurance 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 You Pay Overed outpatient items in accord with our drug formulary guidelines: Most generic (Tier 1) refills through our mail-order service.				tible decer't erryly)	
Primary Care Visits and Non-Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone					
Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient Surgery and certain other outpatient procedures 30% Coinsurance after Plan Deductible Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in the EOC No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs 30% Coinsurance after Plan Deductible Emergency Health Coverage You Pay Emergency Department visits 30% Coinsurance 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 You Pay Roover ed outpatient items in accord with our drug formulary guidelines: Most generic (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply after Plan Deductible You Pay \$30 for up to a 100-day supply after Plan \$30 for up to a 100-day supply after Plan					
Outpatient Services You Pay Outpatient surgery and certain other outpatient procedures 30% Coinsurance after Plan Deductible Most immunizations (including the vaccine) 30% Coinsurance after Plan Deductible Most X-rays and laboratory tests 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in the EOC No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs 30% Coinsurance after Plan Deductible Emergency Health Coverage You Pay Emergency Department visits 30% Coinsurance 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 You Pay Ambulance Services 30% Coinsurance after Plan Deductible 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 after Plan Deductible %15 for up to a 100-day supply after Plan \$30 for up to a 100-day supply after Plan					
Outpatient surgery and certain other outpatient procedures 30% Coinsurance after Plan Deductible Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and 30% Coinsurance after Plan Deductible Hergency Health Coverage You Pay Emergency Department visits 30% Coinsurance 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) You Pay Ambulance Services 30% Coinsurance after Plan Deductible Prescription Drug Coverage You Pay Covered outpatient items in accord with our drug formulary guidelines: %15 for up to a 30-day supply after Plan Deductible Most generic (Tier 1) refills through our mail-order service \$30 for up to a 100-day supply after Plan			• •		
Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i> No charge (Plan Deductible doesn't apply) Hospitalization Services No charge (Plan Deductible doesn't apply) Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs					
Most X-rays and laboratory tests 30% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and 30% Coinsurance after Plan Deductible Emergency Health Coverage You Pay Emergency Department visits 30% Coinsurance 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) You Pay Ambulance Services You Pay Roovered outpatient items in accord with our drug formulary guidelines: 30% Coinsurance after Plan Deductible Most generic items (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply after Plan Deductible \$30 for up to a 100-day supply after Plan \$30 for up to a 100-day supply after Plan	Outpatient surgery and certain other outpatient procedures		30% Coinsurance aller	No charge (Plan Deductible deesn't apply)	
Preventive X-rays, screenings, and laboratory tests as described in the EOC No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	Most X rays and laboratory tests		30% Coinsurance after	30% Coinsurance after Plan Deductible	
the EOC No charge (Plan Deductible doesn't apply) Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	Preventive X-rays screenings and lab	50% Comsulance alter			
Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs				No charge (Plan Deductible doesn't apply)	
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs			• •		
drugs					
Emergency Health CoverageYou PayEmergency Department visits30% Coinsurance after Plan DeductibleNote: 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 ServicesYou PayAmbulance ServicesYou PayAmbulance Services30% Coinsurance after Plan DeductiblePrescription Drug CoverageYou PayCovered 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 after Plan Deductible\$15 for up to a 100-day supply after Plan				Plan Deductible	
Emergency Department visits 30% Coinsurance 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 Ambulance Services Ambulance Services Overed outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy Most generic (Tier 1) refills through our mail-order service \$15 for up to a 30-day supply after Plan Deductible \$30 for up to a 100-day supply after Plan				You Pay	
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 30% Coinsurance after Plan Deductible Prescription Drug Coverage You Pay Covered outpatient items in accord with our drug formulary guidelines: You Pay Most generic items (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply after Plan Deductible \$30 for up to a 100-day supply after Plan \$30 for up to a 100-day supply after Plan	Emergency Department visits		30% Coinsurance after	Plan Deductible	
instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share) Ambulance Services You Pay Ambulance Services 30% Coinsurance after Plan Deductible Prescription Drug Coverage You Pay Covered outpatient items in accord with our drug formulary guidelines: You Pay Most generic items (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply after Plan Deductible \$30 for up to a 100-day supply after Plan \$30 for up to a 100-day supply after Plan	Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share				
Ambulance Services You Pay Ambulance Services 30% Coinsurance after Plan Deductible Prescription Drug Coverage You Pay Covered outpatient items in accord with our drug formulary guidelines: You Pay Most generic items (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply after Plan Deductible \$30 for up to a 100-day supply after Plan \$30 for up to a 100-day supply after Plan	instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share)				
Ambulance Services 30% Coinsurance after Plan Deductible Prescription Drug Coverage You Pay Covered outpatient items in accord with our drug formulary guidelines: You Pay Most generic items (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply after Plan Deductible Most generic (Tier 1) refills through our mail-order service \$30 for up to a 100-day supply after Plan					
Prescription Drug CoverageYou PayCovered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy Most generic (Tier 1) refills through our mail-order service \$15 for up to a 30-day supply after Plan Deductible \$30 for up to a 100-day supply after Plan					
Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy					
Most generic items (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply after Plan Deductible Most generic (Tier 1) refills through our mail-order service					
Most generic (Tier 1) refills through our mail-order service \$30 for up to a 100-day supply after Plan					
			Deductible		

Proposed Benefit Summary	(continued)
Prescription Drug Coverage	You Pay
Most brand-name items (Tier 2) at a Plan Pharmacy Most brand-name (Tier 2) refills through our mail-order service	
Most specialty items (Tier 4) at a Plan Pharmacy	
Preventive items as described in the EOC	\$10 for up to a 100-day supply (Plan Deductible doesn't apply)
Durable Medical Equipment (DME)	You Pay
DME items as described in the EOC	30% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	You Pay
Inpatient psychiatric hospitalization Individual outpatient mental health evaluation and treatment Group outpatient mental health treatment *The Plan Deductible doesn't apply to your first three visits combined for	\$50 per visit after Plan Deductible* \$25 per visit after Plan Deductible*
substance use disorder treatment Services as described in the EOC.	or primary care, argent care, mentar nearth, and
Substance Use Disorder Treatment	You Pay
Inpatient detoxification Individual outpatient substance use disorder evaluation and treatment Group outpatient substance use disorder treatment *The Plan Deductible doesn't apply to your first three visits combined for substance use disorder treatment Services as described in the EOC.	30% Coinsurance after Plan Deductible \$50 per visit after Plan Deductible* \$5 per visit after Plan Deductible*
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period) Prosthetic and orthotic devices as described in the <i>EOC</i> Diagnosis and treatment of infertility and artificial insemination Assisted reproductive technology ("ART") Services Hospice care	No charge (Plan Deductible doesn't apply) Not covered Not covered No charge (Plan Deductible doesn't apply)
This proposal is a summary and does not include all benefits, member	

or limitations. For a complete description, please refer to the Evidence of Coverage.