Family Coverage

Entire Family of two or

more Members

\$6.000

Proposed Benefit Summary

Benefit Plan 8808 \$750 DED, \$25 OV, 20% IP, \$10/\$30/20% 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

Amounts Per Accumulation Period

Plan Out-of-Pocket Maximum

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.

Self-Only Coverage

(a Family of one Member)

\$3,000

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.

Family Coverage

Each Member in a Family

of two or more Members

\$3,000

| Plan Deductible S750 \$750 \$1,500 | Fian Out-oi-Focket Maximum | φ3,000 | φ3,000 | φ0,000 | |
|---|--|----------|---------------------------|---|--|
| Plan Provider Office Visits Most Primary Care Visits and most Non-Physician Specialist Visits | | * | • | | |
| Most Primary Care Visits and most Non-Physician Specialist Visits. S25 per visit (Plan Deductible doesn't apply) Most Physician Specialist Visits. S25 per visit (Plan Deductible doesn't apply) Moltine 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) Urgent care consultations, evaluations, and treatment. S25 per visit (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by interactive video. Physician Specialist Visits by interactive video. No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by telephone. 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 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. No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans. No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits as described in the EOC. No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn | Drug Deductible | None | None | None | |
| Most Physician Specialist Visits | | | | | |
| Routine physical maintenance exams, including well-woman exams. 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) Worth care consultations, evaluations, and treatment. \$25 per visit (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. **Telehealth Visits** Primary Care Visits and Non-Physician Specialist Visits by interactive video. Physician Specialist Visits by interactive video. Physician Specialist Visits by telephone. **Ou Pay** **Ou Pay** No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by telephone. **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. MRI, most CT, and PET scans. Room 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. **Room and board surgery pepartment visits. **Que Pay** Room 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. **Room 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. **Room 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 d | | | | | |
| Well-child preventive exams (through age 23 months) 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) Urgent care consultations, evaluations, and treatment Most physical, occupational, and speech therapy. Telehealth Visits Primary Care Visits and Non-Physician Specialist Visits by interactive video 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) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests 10 per encounter after Plan Deductible No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't appl | | | | | |
| Scheduled prenatal care exams | | | | | |
| Routine eye exams with a Plan Optometrist | | | No charge (Plan Deduc | | |
| Urgent care consultations, evaluations, and treatment \$25 per visit (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy \$25 per visit after Plan Deductible Telehealth Visits You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video | | | | | |
| Most physical, occupational, and speech therapy | | | | | |
| Primary Care Visits and Non-Physician Specialist Visits by interactive video | | | | | |
| Primary Care Visits and Non-Physician Specialist Visits by interactive video | | | | | |
| video | | | | You Pay | |
| Physician Specialist Visits by interactive video | | | | #ible decen't emply) | |
| Primary Care Visits and Non-Physician Specialist Visits by telephone. Physician Specialist Visits by telephone. 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. MRI, most CT, and PET scans. Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. Emergency 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) Ambulance Services Ambulance Services Ambulance Services Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy. No charge (Plan Deductible doesn't apply) No charge (Plan De | | | | No charge (Plan Deductible doesn't apply) | |
| Physician Specialist Visits by telephone | | | | | |
| Outpatient ServicesYou PayOutpatient surgery and certain other outpatient procedures20% Coinsurance after Plan DeductibleMost immunizations (including the vaccine)No charge (Plan Deductible doesn't apply)Most X-rays and laboratory tests\$10 per encounter after Plan DeductiblePreventive X-rays, screenings, and laboratory tests as described in the EOCNo charge (Plan Deductible doesn't apply)MRI, most CT, and PET scans20% Coinsurance up to a maximum of \$150 procedure after Plan DeductibleHospitalization ServicesYou PayRoom and board, surgery, anesthesia, X-rays, laboratory tests, and drugs20% Coinsurance after Plan DeductibleEmergency Health CoverageYou PayEmergency Department visits20% Coinsurance after Plan DeductibleNote: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Sinstead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share)Ambulance ServicesYou PayAmbulance Services\$150 per trip after Plan DeductiblePrescription Drug CoverageYou PayCovered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy\$10 for up to a 30-day supply (Plan Deductib) | | | | | |
| 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 MRI, most CT, and PET scans No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans No charge (Plan Deductible doesn't apply) Most argery, and PET scans No charge (Plan Deductible doesn't apply) You Pay Ambulance Services You Pay No charge (Plan Deductible doesn't apply) You Pay No charge (Plan Deductible doesn't apply You Pay No | | | | | |
| Most X-rays and laboratory tests | | | | | |
| Preventive X-rays, screenings, and laboratory tests as described in the EOC | | | | | |
| the EOC | | | i iaii Deductible | | |
| MRI, most CT, and PET scans 20% Coinsurance up to a maximum of \$150 procedure after Plan Deductible Hospitalization Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs 20% Coinsurance after Plan Deductible Emergency Health Coverage You Pay Emergency Department visits 20% 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 Sinstead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share) Ambulance Services You Pay Ambulance Services 5150 per trip 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 510 for up to a 30-day supply (Plan Deductible | | | tible doesn't apply) | | |
| Hospitalization Services Room 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 | | | | You Pay | |
| Emergency Health Coverage Emergency Department visits | Room and board, surgery, anesthesia, X-rays, laboratory tests, and | | | | |
| Emergency Department visits | drugs | | 20% Coinsurance after | 20% 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 Sinstead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share) Ambulance Services Ambulance Services Ambulance Services Frescription Drug Coverage Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy Most generic items (Plan Deductible Story of the properties of | | | | | |
| instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share) Ambulance Services Ambulance Services Ambulance Services Tou Pay \$150 per trip 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 \$10 for up to a 30-day supply (Plan Deductib) | | | | | |
| Ambulance Services You Pay Ambulance Services \$150 per trip 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 \$10 for up to a 30-day supply (Plan Deductib) | Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share | | | | |
| Ambulance Services | | | | | |
| Prescription Drug Coverage Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy | | | | | |
| Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy | Ambulance Services | | \$150 per trip after Plan | Deductible | |
| Most generic items (Tier 1) at a Plan Pharmacy\$10 for up to a 30-day supply (Plan Deductib | | | | You Pay | |
| | | | | | |
| doesn't apply) | Most generic items (Tier 1) at a Plan | Pharmacy | | supply (Plan Deductible | |
| 11.27 | | | doesn't apply) | | |

| Proposed Benefit Summary | (continued) | |
|--|---|--|
| Prescription Drug Coverage | You Pay | |
| Most generic (Tier 1) refills through our mail-order service | \$20 for up to a 100-day supply (Plan Deductible doesn't apply) | |
| Most brand-name items (Tier 2) at a Plan Pharmacy | \$30 for up to a 30-day supply (Plan Deductible doesn't apply) | |
| Most brand-name (Tier 2) refills through our mail-order service | \$60 for up to a 100-day supply (Plan Deductible doesn't apply) | |
| Most specialty items (Tier 4) at a Plan Pharmacy | | |
| Durable Medical Equipment (DME) | You Pay | |
| DME items as described in the EOC | 20% 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 | \$12 per visit (Plan Deductible doesn't apply) | |
| Substance Use Disorder Treatment | You Pay | |
| Inpatient detoxification | | |
| Individual outpatient substance use disorder evaluation and treatment | | |
| Group outpatient substance use disorder treatment | \$5 per visit (Plan Deductible doesn't apply) | |
| 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 EOC | No charge (Plan Deductible doesn't apply) | |
| Diagnosis and treatment of infertility and artificial insemination (such | | |
| as outpatient procedures or laboratory tests) as described in the | 500/ 0 : | |
| EOC | · · · · · · · · · · · · · · · · · · · | |
| Assisted reproductive technology ("ART") Services | | |
| Hospice care This proposal is a summary and does not include all benefits, member | no charge (Plan Deductible doesn't apply) | |

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*.