

## Proposed Benefit Summary

### Benefit Plan 16279

\$1,600 DED, \$20 OV, \$250 IP, \$10/\$30/20% RX

## Principal Benefits for

### Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO (1/1/24—12/31/24)

"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	\$3,200	\$3,200	\$6,400
Plan Deductible	\$1,600	\$3,200	\$3,200
Drug Deductible	Not applicable	Not applicable	Not applicable

#### Plan Provider Office Visits

	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits .....	\$20 per visit after Plan Deductible
Most Physician Specialist Visits .....	\$20 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 prenatal care exams .....	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist.....	\$20 per visit (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment .....	\$20 per visit after Plan Deductible
Most physical, occupational, and speech therapy .....	\$20 per visit after Plan Deductible

#### Telehealth Visits

	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video .....	No charge after Plan Deductible
Physician Specialist Visits by interactive video .....	No charge after Plan Deductible
Primary Care Visits and Non-Physician Specialist Visits by telephone..	No charge after Plan Deductible
Physician Specialist Visits by telephone.....	No charge after Plan Deductible

#### Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures .....	\$150 per procedure after Plan Deductible
Most immunizations (including the vaccine) .....	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests .....	\$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i> .....	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans .....	\$150 per procedure after Plan Deductible

#### Hospitalization Services

	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	\$250 per admission after Plan Deductible

#### Emergency Health Coverage

	You Pay
Emergency Department visits .....	\$100 per visit 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 .....	\$100 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 after Plan Deductible

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**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 after Plan Deductible
Most brand-name items (Tier 2) at a Plan Pharmacy .....	\$30 for up to a 30-day supply after Plan Deductible
Most brand-name (Tier 2) refills through our mail-order service .....	\$60 for up to a 100-day supply after Plan Deductible
Most specialty items (Tier 4) at a Plan Pharmacy .....	20% Coinsurance (not to exceed \$250) for up to a 30-day supply after Plan Deductible

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

DME items as described in the <i>EOC</i> .....	20% Coinsurance after Plan Deductible
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**Mental Health Services****You Pay**

Inpatient psychiatric hospitalization .....	\$250 per admission after Plan Deductible
Individual outpatient mental health evaluation and treatment .....	\$20 per visit after Plan Deductible
Group outpatient mental health treatment .....	\$10 per visit after Plan Deductible

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

Inpatient detoxification .....	\$250 per admission after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment .....	\$20 per visit after Plan Deductible
Group outpatient substance use disorder treatment .....	\$5 per visit 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) .....	\$250 per admission 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*.