Principal benefits for Kaiser Permanente Deductible HMO Plan

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.

<table>
<thead>
<tr>
<th>Amounts Per Accumulation Period</th>
<th>Self-Only Coverage (a Family of one Member)</th>
<th>Family Coverage Each Member in a Family of two or more Members</th>
<th>Family Coverage Entire Family of two or more Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Out-of-Pocket Maximum</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Drug Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

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

$20 per visit (Plan Deductible doesn’t apply)
$20 per visit (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 (Plan Deductible doesn’t apply)
$20 per visit (Plan Deductible doesn’t apply)
$20 per visit 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 (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)

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

You Pay

20% Coinsurance after Plan Deductible
No charge (Plan Deductible doesn’t apply)
$10 per encounter after Plan Deductible
No charge (Plan Deductible doesn’t apply)
20% Coinsurance up to a maximum of $50 per procedure after Plan Deductible

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

You Pay

20% Coinsurance after Plan Deductible

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 instead of the Emergency Department Cost Share (see “Hospitalization Services” for inpatient Cost Share)

You Pay

20% Coinsurance after Plan Deductible

Ambulance Services
Ambulance Services

You 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
Most generic (Tier 1) refills through our mail-order service

You Pay

$10 for up to a 30-day supply (Plan Deductible doesn’t apply)
$20 for up to a 100-day supply (Plan Deductible doesn’t apply)

(continues)
Disclosure Form Part One

Prescription Drug Coverage

You Pay

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 ........................... 20% Coinsurance (not to exceed $150) for up to a 30-day supply (Plan Deductible doesn’t apply)

Durable Medical Equipment (DME)

You Pay

DME items as described in the EOC................................................ 20% Coinsurance (Plan Deductible doesn’t apply)

Mental Health Services

Inpatient psychiatric hospitalization.............................................. 20% Coinsurance after Plan Deductible

Individual outpatient mental health evaluation and treatment ........ $20 per visit (Plan Deductible doesn’t apply)

Group outpatient mental health treatment.................................... $10 per visit (Plan Deductible doesn’t apply)

Substance Use Disorder Treatment

Inpatient detoxification................................................................... 20% Coinsurance after Plan Deductible

Individual outpatient substance use disorder evaluation and treatment $20 per visit (Plan Deductible doesn’t apply)

Group outpatient substance use disorder treatment........................ $5 per visit (Plan Deductible doesn’t apply)

Home Health Services

Inpatient psychiatric hospitalization.............................................. 20% Coinsurance after Plan Deductible

Individual outpatient mental health evaluation and treatment ........ $20 per visit (Plan Deductible doesn’t apply)

Group outpatient mental health treatment.................................... $10 per visit (Plan Deductible doesn’t apply)

Skilled nursing facility care (up to 100 days per benefit period)........ 20% Coinsurance after Plan Deductible

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 EOC ............................... 50% Coinsurance (Plan Deductible doesn’t apply)

Assisted reproductive technology (“ART”) Services ........................ Not covered

Hospice care .................................................................................. No charge (Plan Deductible doesn’t apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).