**Proposed Benefit Summary**

**Benefit Plan 13850**
**$5,500 DED, $50 OV, 40% IP, $15/40%/40% 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 | $7,000 | $7,000 | $14,000 |
| Plan Deductible | $5,500 | $5,500 | $11,000 |
| Drug Deductible | Not applicable | Not applicable | Not applicable |

| Plan Provider Office Visits | You Pay |
|---|---|
| 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) |
| 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 | $50 per visit after Plan Deductible |
| Most physical, occupational, and speech therapy | $50 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 | 40% Coinsurance after Plan Deductible |
| Most immunizations (including the vaccine) | No charge (Plan Deductible doesn't apply) |
| Most X-rays and laboratory tests | 40% 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 | 40% Coinsurance after Plan Deductible |

| Emergency Health Coverage | You Pay |
|---|---|
| Emergency Department visits | 40% 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 | 40% 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 |


*(continues)*

**Proposed Benefit Summary** *(continued)*

| **Prescription Drug Coverage** | **You Pay** |
|---|---|
| Most generic (Tier 1) refills through our mail-order service | $30 for up to a 100-day supply after Plan Deductible |
| Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service | 40% Coinsurance (not to exceed $100) for up to a 100-day supply after Plan Deductible |
| Most specialty items (Tier 4) at a Plan Pharmacy | 40% Coinsurance (not to exceed $250) for up to a 30-day supply after Plan Deductible |
| 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* | 40% Coinsurance after Plan Deductible |
| **Mental Health Services** | **You Pay** |
| Inpatient psychiatric hospitalization | 40% Coinsurance after Plan Deductible |
| Individual outpatient mental health evaluation and treatment | $50 per visit after Plan Deductible |
| Group outpatient mental health treatment | $25 per visit after Plan Deductible |
| **Substance Use Disorder Treatment** | **You Pay** |
| Inpatient detoxification | 40% Coinsurance after Plan Deductible |
| Individual outpatient substance use disorder evaluation and treatment | $50 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 |
| **Other** | **You Pay** |
| Skilled nursing facility care (up to 100 days per benefit period) | 40% Coinsurance after Plan Deductible |
| Prosthetic and orthotic devices as described in the *EOC* | 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*.