### Principal benefits for Kaiser Permanente Traditional 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.

<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>$1,500</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Drug Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

#### Professional Services (Plan Provider office visits)

You Pay

- Most Primary Care Visits and most Non-Physician Specialist Visits ............................................... $15 per visit
- Most Physician Specialist Visits ........................................................................................................... $15 per visit
- Routine physical maintenance exams, including well-woman exams ...................................................... No charge
- Well-child preventive exams (through age 23 months) ............................................................................ No charge
- Family planning counseling and consultations .......................................................................................... No charge
- Scheduled prenatal care exams ................................................................................................................... No charge
- Routine eye exams with a Plan Optometrist .................................................................................................. No charge
- Urgent care consultations, evaluations, and treatment .............................................................................. $15 per visit
- Most physical, occupational, and speech therapy .......................................................................................... $15 per visit

#### Outpatient Services

You Pay

- Outpatient surgery and certain other outpatient procedures ................................................................. $15 per procedure
- Allergy antigens (including administration) ............................................................................................... $5 per visit
- Most immunizations (including the vaccine) ................................................................................................. No charge
- Most X-rays and laboratory tests ................................................................................................................ No charge

#### Hospitalization Services

You Pay

- Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs ........................................ No charge

#### Emergency Health Coverage

You Pay

- Emergency Department visits ...................................................................................................................... $100 per visit

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

#### 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 per drug for up to a 30-day supply
  - Most generic (Tier 1) refills through our mail-order service ........................................................................ $20 per drug for up to a 100-day supply
  - Most brand-name items (Tier 2) at a Plan Pharmacy ...................................................................................... $30 per drug for up to a 30-day supply
  - Most brand-name (Tier 2) refills through our mail-order service ................................................................. $60 per drug for up to a 100-day supply
  - Most specialty items (Tier 4) at a Plan Pharmacy .......................................................................................... 20% Coinsurance (not to exceed $150) per drug for up to a 30-day supply

#### Durable Medical Equipment (DME)

You Pay

- DME items as described in the EOC .............................................................................................................. 20% Coinsurance

#### Mental Health Services

You Pay

- Inpatient psychiatric hospitalization ............................................................................................................... No charge
- Individual outpatient mental health evaluation and treatment ................................................................. $15 per visit
- Group outpatient mental health treatment .................................................................................................... $7 per visit

#### Substance Use Disorder Treatment

You Pay

- Inpatient detoxification ................................................................................................................................. No charge
- Individual outpatient substance use disorder evaluation and treatment ....................................................... $15 per visit
- Group outpatient substance use disorder treatment ....................................................................................... $5 per visit

(continues)
## Disclosure Form Part One

### Home Health Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (up to 100 visits per Accumulation Period)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglasses or contact lenses every 24 months</td>
<td>Amount in excess of $175 Allowance</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per benefit period)</td>
<td>No charge</td>
</tr>
<tr>
<td>Prosthetic and orthotic devices as described in the EOC</td>
<td>No charge</td>
</tr>
<tr>
<td>Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the EOC</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Assisted reproductive technology (&quot;ART&quot;) Services</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospice care</td>
<td>No charge</td>
</tr>
</tbody>
</table>

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).