Note:
For Out-of-Pocket Accumulation
"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.

<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>$5,000</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>$2,500</td>
<td>$3,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Drug Deductible</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Plan Provider Office Visits**
You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits... 20% Coinsurance after Plan Deductible
Most Physician Specialist Visits .......................................................... 20% Coinsurance 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 No charge (Plan Deductible)
Most physical, occupational, and speech therapy No charge 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 20% Coinsurance after Plan Deductible
Most immunizations (including the vaccine) No charge (Plan Deductible doesn’t apply)
Most X-rays and laboratory tests 20% 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 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 Share instead of the Emergency Department Cost Share (see “Hospitalization Services” for inpatient Cost Share)

**Ambulance Services**
You Pay
Ambulance Services 20% 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 or through our mail-order service 20% Coinsurance (not to exceed $50) for up to a 100-day supply after Plan Deductible

(continues)
Disclosure Form Part One

Prescription Drug Coverage
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service
Most specialty items (Tier 4) at a Plan Pharmacy

Durable Medical Equipment (DME)
Base DME items as described in the EOC (supplemental DME items are not covered)

Mental Health Services
Inpatient psychiatric hospitalization
Individual outpatient mental health evaluation and treatment
Group outpatient mental health treatment

Substance Use Disorder Treatment
Inpatient detoxification
Individual outpatient substance use disorder evaluation and treatment
Group outpatient substance use disorder treatment

Home Health Services
Home health care (up to 120 visits per Accumulation Period)

Other
Skilled nursing facility care (up to 120 days per benefit period)
Prosthetic and orthotic devices as described in the EOC
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the EOC
Assisted reproductive technology ("ART") Services (such as outpatient procedures or laboratory tests) as described in the EOC (one treatment cycle lifetime maximum)
Hospice care

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).

You Pay
20% Coinsurance (not to exceed $100) for up to a 100-day supply after Plan Deductible
50% Coinsurance (not to exceed $250) for up to a 30-day supply after Plan Deductible

You Pay
20% Coinsurance after Plan Deductible

You Pay
20% Coinsurance after Plan Deductible
20% Coinsurance after Plan Deductible
20% Coinsurance after Plan Deductible

You Pay
20% Coinsurance after Plan Deductible
20% Coinsurance after Plan Deductible
20% Coinsurance after Plan Deductible

You Pay
No charge after Plan Deductible

You Pay
20% Coinsurance after Plan Deductible
20% Coinsurance after Plan Deductible

You Pay
see EOC for Cost Share

You Pay
see EOC for Cost Share

You Pay
No charge after Plan Deductible

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).