Principal benefits for
Kaiser Permanente Traditional HMO Plan
(1/1/21—12/31/21)

Accumulation Period
The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)
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</th>
<th>Family Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(a Family of one Member)</td>
<td>Each Member in a Family of two or more Members</td>
<td>Entire Family of two or more Members</td>
</tr>
<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......................... $10 per visit
Most Physician Specialist Visits ........................................................................... $10 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 ............................................. $10 per visit
Most physical, occupational, and speech therapy................................................ $10 per visit

Outpatient Services
You Pay
Outpatient surgery and certain other outpatient procedures ..................................... $10 per procedure
Allergy antigens (including administration) ............................................................. No charge
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 .................................................................................. $50 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 .................................................................................................. No charge

Prescription Drug Coverage
You Pay

Covered outpatient items in accord with our drug formulary guidelines:
Most generic items at a Plan Pharmacy or through our mail-order service .......... $10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service.... $10 for up to a 100-day supply
Most specialty items at a Plan Pharmacy ................................................................. $10 for up to a 30-day supply

Durable Medical Equipment (DME)
You Pay
DME items as described in the EOC......................................................................... No charge

Mental Health Services
You Pay
Inpatient psychiatric hospitalization ................................................................. No charge
Individual outpatient mental health evaluation and treatment......................... $10 per visit
Group outpatient mental health treatment......................................................... $5 per visit

Substance Use Disorder Treatment
You Pay
Inpatient detoxification .......................................................................................... No charge
Individual outpatient substance use disorder evaluation and treatment ............ $10 per visit
Group outpatient substance use disorder treatment ........................................... $5 per visit

Home Health Services
You Pay
Home health care (up to 100 visits per Accumulation Period) ..................... No charge

(continues)
### Disclosure Form

<table>
<thead>
<tr>
<th>Other</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<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>Services to diagnose or treat infertility and artificial insemination</td>
<td>the Cost Share you would pay if the Services were to treat any other condition</td>
</tr>
<tr>
<td>(such as outpatient procedures or laboratory tests) as described in the EOC</td>
<td></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).