CSEBA BRONZE II

Principal Benefits for Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO (2020/2021 Plan Year)

"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 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.

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 deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

Note: The Plan Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.

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	$5,600	$5,600	$11,200
Plan Deductible	$2,800	$2,800	$5,600
Drug Deductible	Not applicable	Not applicable	Not applicable

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit after Plan Deductible
Most Physician Specialist Visits	$10 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)
Family planning counseling and consultations	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	$10 per visit after Plan Deductible
Most physical, occupational, and speech therapy	$10 per visit after Plan Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	$10 per visit 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: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (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 at a Plan Pharmacy	$10 for up to a 30-day supply after Plan Deductible
Most generic refills through our mail-order service	$20 for up to a 100-day supply after Plan Deductible
Most brand-name items at a Plan Pharmacy	$25 for up to a 30-day supply after Plan Deductible
Most brand-name refills through our mail-order service	$50 for up to a 100-day supply after Plan Deductible
Most specialty items at a Plan Pharmacy	30% Coinsurance (not to exceed $150) for up to a 30-day supply after Plan Deductible

(continues)

Benefit Summary *(continued)*

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	20% Coinsurance after Plan Deductible

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$10 per visit after Plan Deductible
Group outpatient mental health treatment	$5 per visit after Plan Deductible

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$10 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)	20% 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 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).