KAISER PERMANENTE®

Customer Name: ROBERT HALF **Customer ID: 17708**

Kaiser Permanente Hawaii Deductible HMO Plan (01/01/2022— 12/31/2022)

Accumulation Period

The Accumulation Period for this plan is 1/1/2022 through 12/31/2022 (calendar year).

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.

Amounts Per Accumulation Period	Member Coverage (Per Member)	Family Coverage Entire Family of three or more Members
Plan Out-of-Pocket Maximum	$2,200	$4,400
Plan Deductible	**$200**	**$400**
Specialty Drug Deductible	**$250**	**$500**

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 copay per visit; Plan Deductible doesn't apply
Most Physician Specialist Visits	$15 copay per visit; Plan Deductible doesn't apply
Routine physical maintenance exams, including well-woman exams (1)	No charge per visit; Plan Deductible doesn't apply
Well-child preventive exams (18 months and younger) (2)	No charge per visit; Plan Deductible doesn't apply
Family planning counseling and consultations	No charge per visit; Plan Deductible doesn't apply
Scheduled prenatal care exams & 1st Postnatal exam	$15 copay for initial visit; no charge for scheduled routine visits & 1st postnatal exam; Plan Deductible doesn't apply
Routine eye exams with a Plan Optometrist or Ophthalmologist	$15 copay per visit; Plan Deductible doesn't apply
Hearing exams	$15 copay per visit; Plan Deductible doesn't apply
Most physical, occupational, and speech therapy	$15 copay per visit; Plan Deductible doesn't apply
Urgent care consultations, evaluations, and treatment	$15 copay per visit at Kaiser Permanente facilities within the Hawaii Service Area; 20% of applicable charges at non-Kaiser Permanente facilities outside the Hawaii Service Area; Plan Deductible doesn't apply

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	10% Coinsurance per procedure after Plan Deductible
Most immunizations (travel immunizations not covered)	No charge; Plan Deductible doesn't apply
Most **basic** laboratory tests	$20 copay per day; Plan Deductible doesn't apply
Most **basic** X-rays	$20 copay per day; Plan Deductible doesn't apply
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge; Plan Deductible doesn't apply
Specialty labs and x-rays, including MRI, most CT, and PET scan	20% Coinsurance per test after Plan Deductible
Radiation Therapy	20% Coinsurance; Plan Deductible doesn't apply
Covered individual health education counseling	$15 copay per visit; Plan Deductible doesn't apply
$500 copay for bariatric counselling; $100 copay for weight management counselling	

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	10% Coinsurance after Plan Deductible

Emergency Health Coverage	You Pay
Emergency Department visits	20% Coinsurance per visit; Plan Deductible doesn't apply to physician services. 20% Coinsurance after Plan Deductible applies to any Specialty Labs and X-rays performed during emergency room visit. Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

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Ambulance Services	**You Pay**
Ambulance Services	20% Coinsurance per trip; Plan Deductible doesn't apply

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines. Plan Deductible does apply to generic or brand-name items	
Most maintenance drugs at a retail Plan Pharmacy (3)	$10 copay for up to a 30-day supply;
Most maintenance drugs through our mail order service (4)	$20 copay for up to a 90-day supply
Most generic items at a retail Plan Pharmacy (3)	$20 copay for up to a 30-day supply
Most generic refills through our mail-order service (4)	$40 copay for up to a 90-day supply
Most brand-name items at a retail Plan Pharmacy (3)	50% Coinsurance for up to a 30-day supply
Most brand-name refills through our mail-order service (4)	50% Coinsurance for up to a 90-day supply
Most specialty items at a retail Plan Pharmacy (3)	50% Coinsurance after Drug Deductible for up to a 30-day supply

Durable Medical Equipment (DME)	**You Pay**
DME items in accord with our DME formulary guidelines	10% Coinsurance
Plan Deductible doesn't apply to DME items	50% Coinsurance for diabetic equipment

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	10% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$15 copay per visit; Plan Deductible doesn't apply
Group outpatient mental health treatment	$15 copay per visit; Plan Deductible doesn't apply

Chemical Dependency Services	**You Pay**
Inpatient detoxification	10% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	$15 copay per visit; Plan Deductible doesn't apply
Group outpatient chemical dependency treatment	$15 copay per visit; Plan Deductible doesn't apply

Home Health Services	**You Pay**
Home health care	No charge (office visit copays apply to physician visits)
Nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician). Plan Deductible doesn't apply	

Other	**You Pay**
Skilled nursing facility care (up to 120 days per calendar year)	10% Coinsurance after Plan Deductible
Hospice care	No charge (office visit copays apply to physician visits)
Hearing Aids	10% Coinsurance of applicable charges; provided every r
provided every 36 months for each hearing impaired ear; Plan Deductible doesn't apply	
Chiropractic care (up to 20 visits per calendar year)	$20 copay

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).

Notes:

(1) One well-woman office visit or office visit for physical exam per calendar year. Preventive screenings covered at no charge include all services mandated by the Patient Protection and Affordable Care Act.
(2) At birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months.
(3) Up to a 30-consecutive-day supply or an amount determined by the Health Plan formulary.
(4) Applies to refills for most maintenance drugs. The mail-order program does not apply to certain drugs and mailing is limited to addresses inside the Hawaii Service Area.

Hawaii Deductible HMO Benefit Summary