## The Connected Care Copay Plan from Kaiser Permanente
## Intel Corporation 2024 Employee Benefit Summary, Northwest

The services described below are covered only if all the terms and conditions in the *Summary Plan Description* are satisfied.

| PLAN FEATURES | In Network | Out of Network |
|---|---|---|
| **Annual deductible for certain services** | | |
| Per person/Per family | None | $250/$500 |
| **Annual out-of-pocket maximum for certain services** | | |
| Per person/Per family | $1500/$3000 | |
| **Professional services** | YOU PAY | |
| Routine preventive physical exams | No charge | 40% after Deductible |
| Routine preventive immunizations (office visit may apply) | No charge | 40% after Deductible |
| Primary care | $10 | 40% after Deductible |
| Specialty care | $25 | 40% after Deductible |
| Well-child preventive care visits Age limits defined by Health Care Reform legislation | No charge | 40% after Deductible |
| Family planning visits (Non-HRSA) | $10 Primary/$25 Specialty | 40% after Deductible |
| Counseling re: contraceptive methods, Implantable or Injectable Contraceptives | No charge | 40% after Deductible |
| Scheduled prenatal care visits and first postpartum visits | No charge | 40% after Deductible |
| Vision exams | Optometrist $10<br>Ophthalmologist $25 | Not covered |
| Routine hearing tests | $10 Primary/$25 Specialty | 40% after Deductible |
| Physical, occupational, and speech therapy visits | $10[i] | 40% after Deductible |
| **Outpatient services** | | |
| Outpatient surgery and certain other outpatient procedures | $100 | 40% after Deductible |
| Allergy injection visits (Office visit cost share may apply) | No charge | 40% after Deductible |
| Allergy testing visits | $25 | 40% after Deductible |
| Non-routine vaccines | $10 Primary/$25 Specialty | 40% after Deductible |
| X-rays and lab tests | No charge | 40% after Deductible |
| **Hospitalization services**[ii] | | |
| Room and board, surgery, anesthesia, X-rays, lab tests, and drugs | $250 per admission | 40% after Deductible |
| Maternity care for mother and newborn | $250 per admission | 40% after Deductible |
| Home Births | $100 | $100 |
| **Emergency health coverage** | | |
| Emergency Department visits (copay waived if admitted) | $100 | $100 |
| Urgent Care | $50 | 40% after Deductible |
| **Ambulance services** | | |
| Ambulance services (per trip) | No charge | No charge |
| **Infertility services** (subject to a $40,000 lifetime maximum per member shared In and Out of Network) See Outpatient Prescription Drug for Infertility Rx Lifetime Max | | |
| Infertility office visits and infertility treatments | $25 | 40% after Deductible |
| Infertility diagnostic lab tests, X-rays, and surgery | No charge | 40% after Deductible |
| **Prescription drug coverage** (most drugs covered in accord with formulary guidelines) Infertility Rx Lifetime Max $20,000 shared In and Out of Network. * Member pays the amount above allowable cost plus the applicable copay as listed below | | |
| Participating pharmacies generic (up to 30-day supply) | $10 | $10* |
| Participating pharmacies brand (up to 30-day supply) | $20 | $20* |
| Participating pharmacies non-formulary brand (up to 30-day supply) | $35 | $35* |
| Mail-order generic (up to 90-day supply) | $20 | Not covered |
| Mail-order brand (up to 90-day supply) | $50 | Not covered |
| Mail-order non-formulary brand (up to 90-day supply) | $90 | Not covered |
| Contraceptives and Contraceptive Devices; Preventive Drugs | No charge | 40% after Deductible |



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|---|---|---|
| **Mental health services** | | |
| Inpatient psychiatric hospitalization, per admission | $250 per admission | 40% after Deductible |
| Day Treatment | $10 | 40% after Deductible |
| Outpatient individual visits | $10 | 40% after Deductible |
| Outpatient group visits | $10 | 40% after Deductible |
| **Chemical dependency services** | | |
| Inpatient detoxification, per admission | $250 per admission | 40% after Deductible |
| Day Treatment | $10 | 40% after Deductible |
| Outpatient individual visits | $10 | 40% after Deductible |
| Outpatient group visits | $10 | 40% after Deductible |
| **Home health services** | | |
| Home health care[iii] | No charge | 40% after Deductible |
| **Other** | | |
| Chiropractic Care[iv] | $15 | 40% after Deductible |
| Acupuncture[iv] | $15 | 40% after Deductible |
| Durable medical equipment | No charge | 40% after Deductible |
| Hospice care | No charge | 40% after Deductible |
| Prescription eyeglasses and contact lenses | Not covered | Not covered |
| Skilled nursing facility care[v] | $250 per admission | 40% after Deductible |
| Treatment of Autism Spectrum Disorders[vi] | | |
| Applied Behavioral Analysis | $10 | $10 |
| Physical, occupational, and speech therapy visits | $10 | 40% after Deductible |

This chart is a summary. It does not explain maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete description of your plan, please refer to Intel's *Pay, Stock and Benefits Handbook*.

Your health benefits are self-insured by your employer, union, or Plan sponsor. Kaiser Permanente provides only administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan.

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[i] Unlimited visits; based on medical necessity.
[ii] Includes room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs.
[iii] No visit limits
[iv] Up to 30 visits per year shared across In and Out of Network
[v] No day limits In Network, 100 day limit per calendar year for Out of Network
[vi] There must be a diagnosis of ASD for benefits to apply. Unlimited visits; based on medical necessity.