Principal Benefits for Kaiser Permanente Traditional HMO Plan (2022/2023 Plan Year)

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.

<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>$4,000</td>
<td>$4,000</td>
<td>$8,000</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
Most Physician Specialist Visits
Routine physical maintenance exams, including well-woman exams
Well-child preventive exams (through age 23 months)
Family planning counseling and consultations
Scheduled prenatal care exams
Routine eye exams with a Plan Optometrist
Urgent care consultations, evaluations, and treatment
Most physical, occupational, and speech therapy

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures
Allergy antigens (including administration)
Most immunizations (including the vaccine)
Most X-rays and laboratory tests
Preventive X-rays, screenings, and laboratory tests as described in the EOC
MRI, most CT, and PET scans

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs

Emergency Health Coverage

You Pay

Emergency Department visits

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 Plan Deductible

Ambulance Services

You Pay

Ambulance Services

Prescription Drug Coverage

You Pay

Covered outpatient items in accord with our drug formulary guidelines:
Most generic items (Tier 1) at a Plan Pharmacy
Most generic (Tier 1) refills through our mail-order service
Most brand-name items (Tier 2) at a Plan Pharmacy
Most brand-name (Tier 2) refills through our mail-order service
Most specialty items (Tier 4) at a Plan Pharmacy

Durable Medical Equipment (DME)

You Pay

DME items as described in the EOC

Mental Health Services

You Pay

Inpatient psychiatric hospitalization
Individual outpatient mental health evaluation and treatment
Group outpatient mental health treatment

Substance Use Disorder Treatment

You Pay

Inpatient detoxification
Individual outpatient substance use disorder evaluation and treatment
Group outpatient substance use disorder treatment

Home Health Services

You Pay

Home health care (up to 100 visits per Accumulation Period)

(continues)
<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>Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the EOC</td>
<td>50% Coinsurance</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 proposal is a summary and does not include all benefits, member cost share, out-of-pocket maximums, exclusions, or limitations. For a complete description, please refer to the Evidence of Coverage.