Benefit Summary

CSEBA/PLAN 12

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.

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	$4,000	$4,000	$8,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$30 per visit
Most Physician Specialist Visits	$30 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	$30 per visit
Most physical, occupational, and speech therapy	$30 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$250 per procedure
Allergy antigens (including administration)	$5 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	$10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge
MRI, most CT, and PET scans	$50 per procedure

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	$150 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	$150 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$15 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service	$30 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	50% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$250 per admission
Individual outpatient mental health evaluation and treatment	$30 per visit
Group outpatient mental health treatment	$15 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$250 per admission
Individual outpatient substance use disorder evaluation and treatment	$30 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)

Benefit Summary *(continued)*

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance
Assisted reproductive technology (“ART”) Services	Not covered
Hospice care	No charge

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*.