Benefit Summary
CSEBA/PLAN 4

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>$1,500</td>
<td>$1,500</td>
<td>$3,000</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)

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Primary Care Visits and most Non-Physician Specialist Visits</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Most Physician Specialist Visits</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Routine physical maintenance exams, including well-woman exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Well-child preventive exams (through age 23 months)</td>
<td>No charge</td>
</tr>
<tr>
<td>Family planning counseling and consultations</td>
<td>No charge</td>
</tr>
<tr>
<td>Scheduled prenatal care exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Routine eye exams with a Plan Optometrist</td>
<td>No charge</td>
</tr>
<tr>
<td>Urgent care consultations, evaluations, and treatment</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Most physical, occupational, and speech therapy</td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

Outpatient Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery and certain other outpatient procedures</td>
<td>$20 per procedure</td>
</tr>
<tr>
<td>Allergy antigens (including administration)</td>
<td>No charge</td>
</tr>
<tr>
<td>Most immunizations (including the vaccine)</td>
<td>No charge</td>
</tr>
<tr>
<td>Most X-rays and laboratory tests</td>
<td>No charge</td>
</tr>
</tbody>
</table>

Hospitalization Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs</td>
<td>$250 per admission</td>
</tr>
</tbody>
</table>

Emergency Health Coverage

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department visits</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

Ambulance Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>$100 per trip</td>
</tr>
</tbody>
</table>

Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered outpatient items in accord with our drug formulary guidelines:</td>
<td>$15 for up to a 30-day supply</td>
</tr>
<tr>
<td>Most generic items (Tier 1) at a Plan Pharmacy</td>
<td>$30 for up to a 100-day supply</td>
</tr>
<tr>
<td>Most generic (Tier 1) refills through our mail-order service</td>
<td>$35 for up to a 30-day supply</td>
</tr>
<tr>
<td>Most brand-name items (Tier 2) at a Plan Pharmacy</td>
<td>$70 for up to a 100-day supply</td>
</tr>
<tr>
<td>Most brand-name (Tier 2) refills through our mail-order service</td>
<td>$35 for up to a 30-day supply</td>
</tr>
<tr>
<td>Most specialty items (Tier 4) at a Plan Pharmacy</td>
<td></td>
</tr>
</tbody>
</table>

Durable Medical Equipment (DME)

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME items as described in the EOC</td>
<td>No charge</td>
</tr>
</tbody>
</table>

Mental Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient psychiatric hospitalization</td>
<td>$250 per admission</td>
</tr>
<tr>
<td>Individual outpatient mental health evaluation and treatment</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Group outpatient mental health treatment</td>
<td>$10 per visit</td>
</tr>
</tbody>
</table>

Substance Use Disorder Treatment

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient detoxification</td>
<td>$250 per admission</td>
</tr>
<tr>
<td>Individual outpatient substance use disorder evaluation and treatment</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Group outpatient substance use disorder treatment</td>
<td>$5 per visit</td>
</tr>
</tbody>
</table>

Home Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (up to 100 visits per Accumulation Period)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

Other

<table>
<thead>
<tr>
<th>Service</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>Other</td>
<td>You Pay</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------</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</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>(such as outpatient procedures or laboratory tests) as described in</td>
<td></td>
</tr>
<tr>
<td>the EOC</td>
<td></td>
</tr>
<tr>
<td>Assisted reproductive technology (“ART”) 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.