Benefit Summary
CSEBA/PLAN 5
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)
You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits ............................................. $5 per visit
Most Physician Specialist Visits ........................................................................................................ $5 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 ........................................................................ $5 per visit
Most physical, occupational, and speech therapy .............................................................................. $5 per visit

Outpatient Services
You Pay
Outpatient surgery and certain other outpatient procedures .......................................................... $5 per procedure
Allergy antigens (including administration) ......................................................................................... No charge
Most immunizations (including the vaccine) ....................................................................................... No charge
Most X-rays and laboratory tests ........................................................................................................ No charge

Hospitalization Services
You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs ........................................ No charge

Emergency Health Coverage
You Pay
Emergency Department visits ................................................................................................................ $50 per visit
Note: If you are admitted directly to the hospital as an inpatient for covered Services, the Emergency Department Cost Share (see “Hospitalization Services” for inpatient

Ambulance Services
You Pay
Ambulance Services .............................................................................................................................. No charge

Prescription Drug Coverage
You Pay
Covered outpatient items in accord with our drug formulary guidelines:
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service $5 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service $5 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy ................................................................................ $5 for up to a 30-day supply

Durable Medical Equipment (DME)
You Pay
DME items as described in the EOC ........................................................................................................ No charge

Mental Health Services
You Pay
Inpatient psychiatric hospitalization ........................................................................................................ No charge
Individual outpatient mental health evaluation and treatment ........................................................ $5 per visit
Group outpatient mental health treatment ........................................................................................ $2 per visit

Substance Use Disorder Treatment
You Pay
Inpatient detoxification ............................................................................................................................ No charge
Individual outpatient substance use disorder evaluation and treatment ........................................ $5 per visit
Group outpatient substance use disorder treatment ........................................................................... $2 per visit

Home Health Services
You Pay
Home health care (up to 100 visits per Accumulation Period) ............................................................. No charge

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

(continues)
### Benefit Summary (continued)

<table>
<thead>
<tr>
<th>Other</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<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.*