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 ........................................ $10 per visit
Most Physician Specialist Visits ......................................................... $10 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 (through age 23 months) ............................. No charge
Routine eye exams with a Plan Optometrist .............................................. No charge
Urgent care consultations, evaluations, and treatment ................................ $10 per visit
Most physical, occupational, and speech therapy ......................................... $10 per visit

Outpatient Services
You Pay

Outpatient surgery and certain other outpatient procedures ........................ $10 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, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share

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
Most brand-name items (Tier 2) at a Plan Pharmacy or 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 .................................................................. No charge

Mental Health Services
You Pay

Inpatient psychiatric hospitalization .............................................................. No charge
Individual outpatient mental health evaluation and treatment ......................... $10 per visit
Group outpatient mental health treatment .................................................... $5 per visit

Substance Use Disorder Treatment
You Pay

Inpatient detoxification .................................................................................. No charge
Individual outpatient substance use disorder evaluation and treatment ........ $10 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

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

<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 <strong>EOC</strong></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**.