Benefit Summary
CSEBA/PLAN 7

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
You Pay $15 per visit
Most Physician Specialist Visits
You Pay $15 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 evaluations, treatments, and treatments
$15 per visit
Most physical, occupational, and speech therapy
$15 per visit

Outpatient Services
You Pay
Outpatient surgery and certain other outpatient procedures
$15 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
$10 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service
$20 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy
$20 for up to a 30-day supply

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
$15 per visit
Group outpatient mental health treatment
$7 per visit

Substance Use Disorder Treatment
You Pay
Inpatient detoxification
No charge
Individual outpatient substance use disorder evaluation and treatment
$15 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)
<table>
<thead>
<tr>
<th>Other</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<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 (&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*. 