Benefit Summary
CSEBA/PLAN 8 with Optical

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>
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<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 .................................................. $20 per visit
- Most Physician Specialist Visits ............................................................................................................. $20 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 ...................................................................................... $20 per visit
- Most physical, occupational, and speech therapy ............................................................................................ $20 per visit

Outpatient Services
You Pay
- Outpatient surgery and certain other outpatient procedures ........................................................................ $20 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 .......................................................................................................................... $100 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 ........................................................................................................................................ 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 ......................................................................................... $10 for up to a 30-day supply
  - Most generic (Tier 1) refills through our mail-order service ...................................................................... $20 for up to a 100-day supply
  - Most brand-name items (Tier 2) at a Plan Pharmacy ................................................................................... $20 for up to a 30-day supply
  - Most brand-name (Tier 2) refills through our mail-order service ................................................................. $40 for up to a 100-day supply
  - Most specialty items (Tier 4) at a Plan Pharmacy ........................................................................................ $20 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 ........................................................................ $20 per visit
- Group outpatient mental health treatment ..................................................................................................... $10 per visit

Substance Use Disorder Treatment
You Pay
- Inpatient detoxification .................................................................................................................................. No charge
- Individual outpatient substance use disorder evaluation and treatment ......................................................... $20 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)
<table>
<thead>
<tr>
<th>Other</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglasses or contact lenses every 24 months</td>
<td>Amount in excess of $150 Allowance</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per benefit period)</td>
<td>No charge</td>
</tr>
<tr>
<td>Prosthetic and orthotic devices as described in the <em>EOC</em></td>
<td>No charge</td>
</tr>
<tr>
<td>Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <em>EOC</em></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>
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</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*. 