

Benefit Summary

CSEBA/Silver

Principal Benefits for Kaiser Permanente Deductible 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.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	\$3,000	\$3,000	\$6,000
Plan Deductible	\$500	\$500	\$1,000
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)

	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	\$20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	\$20 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams.....	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	\$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy.....	\$20 per visit (Plan Deductible doesn't apply)

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures	10% Coinsurance after Plan Deductible
Allergy antigens (including administration).....	No charge (Plan Deductible doesn't apply)
Most immunizations (including the vaccine).....	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	\$10 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i>	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans.....	10% Coinsurance up to a maximum of \$50 per procedure (Plan Deductible doesn't apply)

Hospitalization Services

	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	10% Coinsurance after Plan Deductible

Emergency Health Coverage

	You Pay
Emergency Department visits	10% Coinsurance after Plan Deductible
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	\$150 per trip (Plan Deductible doesn't apply)

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 (Plan Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service.....	\$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy	\$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name (Tier 2) refills through our mail-order service	\$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed \$150) for up to a 30-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment (DME)

	You Pay
DME items as described in the <i>EOC</i>	20% Coinsurance (Plan Deductible doesn't apply)

Mental Health Services

	You Pay
Inpatient psychiatric hospitalization.....	10% Coinsurance after Plan Deductible

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Benefit Summary

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Mental Health Services

Individual outpatient mental health evaluation and treatment	\$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment.....	\$10 per visit (Plan Deductible doesn't apply)

Substance Use Disorder Treatment

Inpatient detoxification	10% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment.....	\$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	\$5 per visit (Plan Deductible doesn't apply)

Home Health Services

Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
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Other

Skilled nursing facility care (up to 100 days per benefit period)	10% Coinsurance (Plan Deductible doesn't apply)
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i>	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services.....	Not covered
Hospice care	No charge (Plan Deductible doesn't apply)

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*.