Benefit Summary
1659 ELK GROVE SCHOOL DISTRICT - CERT

Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/21—12/31/21)

Accumulation Period
The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)
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>
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</tbody>
</table>

Professional Services (Plan Provider office visits)  You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits $30 per visit
Most Physician Specialist Visits $30 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 $30 per visit
Most physical, occupational, and speech therapy $30 per visit

Outpatient Services  You Pay

Outpatient surgery and certain other outpatient procedures $30 per procedure
Allergy antigens (including administration) $3 per visit
Most immunizations (including the vaccine) No charge
Most X-rays and laboratory tests $10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the EOC No charge
MRI, most CT, and PET scans $50 per procedure

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 at a Plan Pharmacy $15 for up to a 30-day supply
  Most generic refills through our mail-order service $30 for up to a 100-day supply
  Most brand-name items at a Plan Pharmacy $35 for up to a 30-day supply
  Most brand-name refills through our mail-order service $70 for up to a 100-day supply
  Most specialty items at a Plan Pharmacy $35 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 $30 per visit
Group outpatient mental health treatment $15 per visit

Substance Use Disorder Treatment  You Pay

Inpatient detoxification No charge
Individual outpatient substance use disorder evaluation and treatment $30 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

12826.156.1.S000605322 - TRADITIONAL HMO $30 PLAN (continues)
<table>
<thead>
<tr>
<th>Other</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aid(s) every 36 months</td>
<td>Amount in excess of $1,000 Allowance per aid</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>
</tr>
</tbody>
</table>

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).