
Disclosure Form605299 CSAC EIA - SAN BENITO COUNTY
Home Region: Northern California**Principal benefits for
Kaiser Permanente Traditional HMO Plan**

(1/1/19—12/31/19)

Accumulation Period

The Accumulation Period for this plan is 1/1/19 through 12/31/19 (calendar year).

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.

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	\$1,500	\$1,500	\$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)**You Pay**

Most Primary Care Visits and most Non-Physician Specialist Visits	\$15 per visit
Most Physician Specialist Visits	\$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 consultations, evaluations, and treatment	\$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 injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services**You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
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Emergency Health Coverage**You Pay**

Emergency Department visits	\$50 per visit
Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	

Ambulance Services**You Pay**

Ambulance Services	No charge
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Prescription Drug Coverage**You Pay**

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items at a Plan Pharmacy	\$5 for up to a 30-day supply
Most generic refills through our mail-order service	\$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	\$20 for up to a 30-day supply
Most brand-name refills through our mail-order service	\$40 for up to a 100-day supply
Most specialty items 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
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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
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Disclosure Form*(continued)*

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
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Other**You Pay**

Hearing aid(s) every 36 months	Amount in excess of \$500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge
Covered Services for diagnosis and treatment of infertility	50% Coinsurance
Hospice care	No charge

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).