## **Benefit Summary**

## **HDIEET PLAN 2**

# Principal Benefits for Kaiser Permanente Traditional HMO Plan (7/1/20-6/30/21)

**Self-Only Coverage** 

#### **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.

**Family Coverage** 

**Family Coverage** 

Plan Out-of-Pocket Maximum	Amounts Per Accumulation Period	(a Family of one Member)	Each Member in a Family of two	Entire Family of two or more	
Plan Deductible   None   Non		· · · · · · · · · · · · · · · · · · ·	or more Members		
Drug Deductible   None   None   None   None   None   Professional Services (Plan Provider office visits )   You Pay	Plan Out-of-Pocket Maximum	\$1,500	\$1,500	\$3,000	
Professional Services (Plan Provider office visits)  Wos Primary Care Visits and most Non-Physician Specialist Visits.  S20 per visit  Most Physician Specialist Visits.  S20 per visit  Routine physical maintenance exams, including well-woman exams  No charge  Well-child preventive exams (through age 23 amonts)  No charge  Scheduled prenatal care exams.  No charge  Scheduled prenatal care exams.  No charge  Routine eye exams with a Plan Optometrist.  No charge  Routine eye exams with a Plan Optometrist.  No charge  Well-child prevants with a Plan Optometrist.  No charge  Scheduled prenatal care exams.  No charge  Wegen care consultations, evaluations, and treatment.  S20 per visit  Most physical, occupational, and speech therapy.  S20 per visit  Wost physical, occupational, and speech therapy.  S20 per visit  Most physical, occupational, and speech therapy.  S50 per procedure  Allergy injections (including allergy serum).  S5 per visit  Most immunizations (including allergy serum).  S5 per visit  Most Taryas and aboratory tests.  No charge  Hospitalization Services  You Pay  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  No charge  Hospitalization Services  You Pay  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  No charge  Most Pays and aboratory tests.  You Pay  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  No charge  Hospitalization Services  You Pay  Prescription Drug Coverage  You Pay  Work  Wor	Plan Deductible	None	None	None	
Most Primary Care Visits and most Non-Physician Specialist Visits	Drug Deductible	None	None	None	
Most Physician Specialist Visits.  S20 per visit  No charge  Well-child preventive exams (through age 23 months).  No charge  Well-child preventive exams (through age 23 months).  No charge  Routine eye exams with a Plan Optometrist  Most physical, occupational, and speech therapy.  S20 per visit  Most physical, occupational, and speech therapy.  S20 per visit  Most physical, occupational, and speech therapy.  S20 per visit  Outpatient surgery and certain other outpatient procedures.  Allergy injections (including allergy serun).  S5 per visit  Most immunizations (including the vaccine).  Most immunizations (including the vaccine).  Most and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  No charge  Most way  No charge  Most May  Most physical oscope the vaccine of the v	Professional Services (Plan Provider office visits)  You Pay				
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Well-child preventive exams (through age 23 months)					
Family planning counseling and consultations.  Scheduled prenatal care exams.  Routine eye exams with a Plan Optometrist.  Wos charge Ruutine eye exams with a Plan Optometrist.  No charge Ruutine cye exams with a Plan Optometrist.  Outpatications, evaluations, and treatment.  \$20 per visit  Outpatient Services  You Pay  Outpatient Surgery and certain other outpatient procedures.  \$20 per procedure  Allergy injections (including allergy serum).  \$5 per visit  Most immunizations (including allergy serum).  \$5 per visit  Most immunizations (including allergy serum).  No charge  Most X-rays and laboratory tests.  No charge  Most X-rays and laboratory tests.  No charge  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  Rom and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  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 does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient 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).  **Mobulance Services**  You Pay  **Covered outpatient items in accord with our drug formulary guidelines:  **Most generic crefilis through our mail-order service.  \$20 for up to a 30-day supply Most brand-name items at a Plan Pharmacy.  \$20 for up to a 100-day supply Most brand-name items at a Plan Pharmacy.  \$20 for up to a 100-day supply Most brand-name refilis through our mail-order service.  \$20 for up to a 100-day supply Most brand-name refilis through our mail-order service.  \$20 for up to a 100-day supply Most brand-name refilis through our mail-order service.  \$20 for up to a 30-day supply Most brand-name items at a Plan Pharmacy.  \$20 for up to a 30-day supply Most brand-name items at a Plan Pharmacy.  \$20 for up to a					
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Most physical, occupational, and speech therapy					
Outpatient Services         You Pay           Outpatient surgery and certain other outpatient procedures         \$20 per procedure           Allergy injections (including allergy serum)         \$5 per visit           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: 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).         You Pay           Ambulance Services         You Pay           Prescription Drug Coverage         You Pay           Covered outpatient items in accord with our drug formulary guidelines:         Most generic refills through our mail-order service         \$10 for up to a 30-day supply           Most generic refills through our mail-order service         \$20 for up to a 100-day supply           Most brand-name items at a Plan Pharmacy         \$30 for up to a 30-day supply           Most specialty items at a Plan Pharmacy         \$60 for up to a 100-day supply           Most specialty items at a Plan Pharmacy         200 coinsurance (not to	-				
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Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	Most X-rays and laboratory tests		No charge		
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Emergency Department visits	Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs		_		
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Most brand-name refills through our mail-order service					
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Durable Medical Equipment (DME)  DME items as described in the EOC					
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Group outpatient mental health treatment \$10 per visit  Substance Use Disorder Treatment You Pay  Inpatient detoxification					
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Inpatient detoxification	Group outpatient mental health treatment		\$10 per visit		
Individual outpatient substance use disorder evaluation and treatment			•		
	·		J		
Group outpatient substance use disorder treatment					
	Group outpatient substance use disorder treat	\$5 per visit			

Benefit Summary	(continued)		
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		
Diagnosis and treatment of infertility and artificial insemination (such as outpatient			
procedures or laboratory tests) as described in the EOC	50% Coinsurance		
Assisted reproductive technology ("ART") Services	Not covered		
Hospice care	No charge		
Chiropractic Benefit (30 visits per calendar year)	\$10 per visit		

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).