Benefit Summary

HDIEET PLAN 3

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

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.

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	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	$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 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	$250 per admission

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).

Ambulance Services	**You Pay**
Ambulance Services	$50 per trip

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$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 brand-name refills through our mail-order service	$60 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	20% Coinsurance (not to exceed $150) 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	$250 per admission
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	$250 per admission
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

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).