

## Disclosure Form

104303 CITY OF SAN DIEGO  
Home Region: Southern California

# Principal benefits for Kaiser Permanente Traditional HMO Plan

(8/1/20—7/31/21)

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Contact Center.

### 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	\$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 .....	\$20 per visit
Most Physician Specialist Visits .....	\$20 per visit
Routine physical maintenance exams, including well-woman exams .....	\$20 per visit
Well-child preventive exams (through age 23 months) .....	\$5 per visit
Family planning counseling and consultations .....	\$20 per visit
Scheduled prenatal care exams .....	\$5 per visit
Routine eye exams with a Plan Optometrist .....	\$20 per visit
Urgent care consultations, evaluations, and treatment .....	\$20 per visit
Most physical, occupational, and speech therapy .....	\$20 per visit

### Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures .....	\$50 per procedure
Allergy injections (including allergy serum) .....	No charge
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 .....	\$100 per admission

### 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

### Prescription Drug Coverage

Covered outpatient items in accord with our drug formulary guidelines:

	You Pay
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 .....	\$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 .....	\$30 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 .....	\$100 per admission
Individual outpatient mental health evaluation and treatment .....	\$20 per visit
Group outpatient mental health treatment .....	\$10 per visit

### Substance Use Disorder Treatment

	You Pay
Inpatient detoxification .....	\$100 per admission
Individual outpatient substance use disorder evaluation and treatment .....	\$20 per visit
Group outpatient substance use disorder treatment .....	\$5 per visit

(continues)

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**Disclosure Form***(continued)***Home Health Services****You Pay**

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Home health care (up to 100 visits per Accumulation Period) .....	No charge
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**Other****You Pay**

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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
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i> .....	see <i>EOC</i> for Cost Share
Assisted reproductive technology ("ART") Services.....	Not covered
Hospice care .....	No charge

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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).