
Benefit Summary

152 CONTRA COSTA COUNTY

**Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/20—12/31/20) (HMO A)**

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.....	\$10 per visit
Most Physician Specialist Visits.....	\$10 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	\$10 per visit
Most physical, occupational, and speech therapy.....	\$10 per visit

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures	\$10 per procedure
Allergy injections (including allergy serum)	\$3 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.....	\$10 per visit

Note: This Cost Share does not apply if you are held for observation in a hospital unit outside the Emergency Department or 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

	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service.....	\$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service.....	\$20 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

Mental Health Services

	You Pay
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment	\$10 per visit
Group outpatient mental health treatment	\$5 per visit

Substance Use Disorder Treatment

	You Pay
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment.....	\$10 per visit

Benefit Summary*(continued)*

Substance Use Disorder Treatment	You Pay
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 <i>EOC</i>	No charge
Services to diagnose or treat 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

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).