### Principal benefits for Kaiser Permanente Traditional HMO Plan

**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.

<table>
<thead>
<tr>
<th>Amounts Per Accumulation Period</th>
<th>Self-Only Coverage (a Family of one Member)</th>
<th>Family Coverage Each Member in a Family of two or more Members</th>
<th>Family Coverage Entire Family of two or more Members</th>
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</thead>
<tbody>
<tr>
<td>Plan Out-of-Pocket Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Drug Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**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 ................................................................. $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 ........................................................................... $15 per visit
- Most physical, occupational, and speech therapy ................................................................................... $15 per visit

**Outpatient Services**
You Pay

- Outpatient surgery and certain other outpatient procedures ................................................................. $150 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 ........................................... $250 per admission

**Emergency Health Coverage**
You Pay

- Emergency Department visits ............................................................................................................... $250 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**
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 ................................... $35 for up to a 100-day supply
- Most specialty items at a Plan Pharmacy .............................................................................................. $35 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 ................................................................. $15 per visit
- Group outpatient mental health treatment ............................................................................................... $7 per visit

**Substance Use Disorder Treatment**
You Pay

- Inpatient detoxification .......................................................................................................................... $250 per admission

(continues)
<table>
<thead>
<tr>
<th><strong>Disclosure Form</strong></th>
<th>(continued)</th>
</tr>
</thead>
</table>
| Individual outpatient substance use disorder evaluation and treatment ........................................ $15 per visit  
Group outpatient substance use disorder treatment ................................................................. $5 per visit  
**Home Health Services**  
Home health care (up to 100 visits per Accumulation Period) ................................................... No charge  
**Other**  
Eyeglasses or contact lenses every 24 months ................................................................................. Amount in excess of $150 Allowance  
Skilled nursing facility care (up to 100 days per benefit period) .................................................... No charge  
Prosthetic and orthotic devices as described in the *EOC* .............................................................. No charge  
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).