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**Disclosure Form**100136 COUNTY OF SAN BERNARDINO  
Home Region: Southern California**Principal benefits for  
Kaiser Permanente Traditional HMO Plan**

(8/1/20—7/31/21)

**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.

<b>Amounts Per Accumulation Period</b>	<b>Self-Only Coverage (a Family of one Member)</b>	<b>Family Coverage Each Member in a Family of two or more Members</b>	<b>Family Coverage Entire Family of two or more Members</b>
Plan Out-of-Pocket Maximum	\$3,500	\$3,500	\$7,000
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 .....	\$40 per visit
Most Physician Specialist Visits .....	\$50 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 .....	\$40 per visit
Most physical, occupational, and speech therapy .....	\$40 per visit

**Outpatient Services****You Pay**

Outpatient surgery and certain other outpatient procedures .....	\$250 per procedure
Allergy injections (including allergy serum) .....	\$5 per visit
Most immunizations (including the vaccine) .....	No charge
Most X-rays and laboratory tests .....	\$10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i> .....	No charge
MRI, most CT, and PET scans .....	\$100 per procedure

**Hospitalization Services****You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	\$500 per day
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**Emergency Health Coverage****You Pay**

Emergency Department visits .....	\$150 per visit
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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 .....	\$150 per trip
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**Prescription Drug Coverage****You Pay**

Covered outpatient items in accord with our drug formulary guidelines:

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 .....	\$35 for up to a 30-day supply
Most brand-name refills through our mail-order service .....	\$70 for up to a 100-day supply
Most specialty items at a Plan Pharmacy .....	30% Coinsurance (not to exceed \$200) for up to a 30-day supply

**Durable Medical Equipment (DME)****You Pay**

DME items as described in the <i>EOC</i> .....	50% Coinsurance
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**Mental Health Services****You Pay**

Inpatient psychiatric hospitalization .....	\$500 per day
Individual outpatient mental health evaluation and treatment .....	\$40 per visit
Group outpatient mental health treatment .....	\$20 per visit

**Substance Use Disorder Treatment****You Pay**

Inpatient detoxification .....	\$500 per day
Individual outpatient substance use disorder evaluation and treatment .....	\$40 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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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> .....	50% Coinsurance
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).