**133411 SOUTHEASTERN CA CONF SEVENTH-DAY ADVEN**

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

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 | 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 | $20 per visit |
| Most physical, occupational, and speech therapy | $20 per visit |

| **Outpatient Services** | **You Pay** |
| --- | --- |
| Outpatient surgery and certain other outpatient procedures | $20 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 | $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 | $100 per trip |

| **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 | $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* | 20% Coinsurance |

| **Mental Health Services** | **You Pay** |
| --- | --- |
| Inpatient psychiatric hospitalization | $250 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 | $250 per admission |
| Individual outpatient substance use disorder evaluation and treatment | $20 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 |
| Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC* | see *EOC* 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).