**Disclosure Form Part One**

100136 COUNTY OF SAN BERNARDINO
Home Region: Southern California

7/30/22 through 7/28/23

# Principal benefits for Kaiser Permanente Traditional HMO Plan

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 Maximums and Deductibles**

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 antigens (including administration) | 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 | No charge |

| Emergency Health Coverage | You Pay |
|---|---|
| Emergency Department visits | $50 per visit |

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (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 (Tier 1) at a Plan Pharmacy or through our mail-order service | $10 for up to a 100-day supply |
| Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service | $15 for up to a 100-day supply |
| Most specialty items (Tier 4) at a Plan Pharmacy | $15 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 |
| Group outpatient substance use disorder treatment | $5 per visit |

*(continues)*

| 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 |
| Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC* | 50% Coinsurance |
| 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).