
Benefit Summary

888 SAN FRANCISCO HEALTH SERVICE SYSTEM

**Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/19—12/31/19)****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.

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.....	\$35 per procedure
Allergy injections (including allergy serum)	\$5 per visit
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.....	\$100 per admission
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Emergency Health Coverage**You Pay**

Emergency Department visits.....	\$100 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.....	No charge
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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	\$5 for up to a 30-day supply
Most generic refills through our mail-order service.....	\$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	\$15 for up to a 30-day supply
Most brand-name refills through our mail-order service.....	\$30 for up to a 100-day supply
Most specialty items at a Plan Pharmacy.....	20% Coinsurance (not to exceed \$100) for up to a 30-day supply

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

DME items as described in the EOC.....	No charge
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Mental Health Services**You Pay**

Inpatient psychiatric hospitalization.....	\$100 per admission
Individual outpatient mental health evaluation and treatment	\$20 per visit

Benefit Summary*(continued)*

Group outpatient mental health treatment \$10 per visit

Substance Use Disorder Treatment**You Pay**

Inpatient detoxification \$100 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**

Hearing aid(s) every 36 months Amount in excess of \$2,500 Allowance per aid

Skilled nursing facility care (up to 100 days per benefit period) No charge

Prosthetic and orthotic devices as described in the *EOC* No charge

All Services related to covered infertility treatment \$20 per visit

All Services related to covered assisted reproductive technology Services subject to 2

treatment cycles per lifetime maximum 50% Coinsurance

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).