Benefit Summary

888 SAN FRANCISCO HEALTH SERVICE SYSTEM

Principal Benefits for Kaiser Permanente Traditional HMO Plan (1/1/18—12/31/18)

Accumulation Period

The Accumulation Period for this plan is 1/1/18 through 12/31/18 (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

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	No charge

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, $10 for a 31- to 60-day supply, or $15 for a 61- to 100-day supply
Most generic refills through our mail-order service	$5 for up to a 30-day supply or $10 for a 31- to 100-day supply
Most brand-name items at a Plan Pharmacy	$15 for up to a 30-day supply, $30 for a 31- to 60-day supply, or $45 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	$15 for up to a 30-day supply or $30 for a 31- to 100-day supply
Most specialty items at a Plan Pharmacy	20% Coinsurance (not to exceed $100) for up to a 30-day supply

(continues)

Benefit Summary *(continued)*

Durable Medical Equipment (DME)	You Pay
DME items as described in this *EOC*	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$100 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	$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 this *EOC*	No charge
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 *Evidence of Coverage*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).