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**Benefit Summary**

2020 REEP - HMO 20

**Principal Benefits for  
Kaiser Permanente Traditional HMO Plan (7/1/20—6/30/21)****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	\$1,500	\$1,500	\$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

**Professional Services (Plan Provider office visits)**

	<b>You Pay</b>
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**

	<b>You Pay</b>
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
MRI, most CT, and PET scans.....	\$20 per procedure
Covered individual health education counseling .....	No charge
Covered health education programs .....	No charge

**Hospitalization Services**

	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	No charge

**Emergency Health Coverage**

	<b>You Pay</b>
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**

	<b>You Pay</b>
Ambulance Services.....	No charge

**Prescription Drug Coverage**

Covered outpatient items in accord with our drug formulary guidelines:

	<b>You Pay</b>
Most generic items at a Plan Pharmacy .....	\$10 for up to a 30-day supply
Most generic refills through our mail-order service.....	\$20 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy .....	\$20 for up to a 30-day supply
Most brand-name refills through our mail-order service.....	\$40 for up to a 100-day supply
Most specialty items at a Plan Pharmacy.....	\$20 for up to a 30-day supply

**Durable Medical Equipment (DME)**

	<b>You Pay</b>
DME items as described in the EOC.....	No charge

**Mental Health Services**

	<b>You Pay</b>
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment .....	\$20 per visit
Group outpatient mental health treatment .....	\$10 per visit

**Substance Use Disorder Treatment**

	<b>You Pay</b>
Inpatient detoxification .....	No charge

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**Benefit Summary***(continued)***Substance Use Disorder Treatment****You Pay**

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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**

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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
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).