Benefit Summary

2019 REEP/ MVP

All Employees

Principal Benefits for Kaiser Permanente Deductible HMO Plan (7/1/19—6/30/20)

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.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum 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	$6,000	$6,000	$12,000
Plan Deductible	$4,500	$4,500	$9,000
Drug Deductible	$250	$250	Not applicable

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$50 per visit after Plan Deductible
Most Physician Specialist Visits	$50 per visit after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$50 per visit after Plan Deductible
Most physical, occupational, and speech therapy	$50 per visit after Plan Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	40% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	$15 per visit after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	40% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	40% Coinsurance up to a maximum of $150 per procedure after Plan Deductible
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (Plan Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	40% Coinsurance after Plan Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	$250 per visit after Plan Deductible
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	40% Coinsurance after Plan Deductible
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 (Drug Deductible doesn't apply)
Most generic refills through our mail-order service	$30 for up to a 100-day supply (Drug Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply after Drug Deductible
Most brand-name refills through our mail-order service	$70 for up to a 100-day supply after Drug Deductible
Most specialty items at a Plan Pharmacy	$35 for up to a 30-day supply after Drug Deductible

(continues)

Benefit Summary *(continued)*

Durable Medical Equipment (DME)	You Pay
Base DME items as described in the *EOC* (supplemental DME items are not covered)	40% Coinsurance (Plan Deductible doesn't apply)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	40% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$50 per visit after Plan Deductible
Group outpatient mental health treatment	$25 per visit after Plan Deductible

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	40% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$50 per visit after Plan Deductible
Group outpatient substance use disorder treatment	$5 per visit after Plan Deductible

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	40% Coinsurance after Plan Deductible
Base prosthetic and orthotic devices as described in the *EOC* (supplemental prosthetic and orthotic devices are not covered)	No charge (Plan Deductible doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)

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).