
Benefit Summary

225576 LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM

**Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/21—12/31/21)**

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 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	\$500	\$500	\$1,500
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.....	\$20 per visit
Well-child preventive exams (through age 23 months).....	\$5 per visit
Family planning counseling and consultations.....	\$20 per visit
Scheduled prenatal care exams.....	\$5 per visit
Routine eye exams with a Plan Optometrist.....	\$20 per visit
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.....	\$20 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
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Emergency Health Coverage**You Pay**

Emergency Department visits.....	\$100 per visit
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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
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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.....	\$15 for up to a 30-day supply
Most generic refills through our mail-order service.....	\$30 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy.....	\$35 for up to a 30-day supply
Most brand-name refills through our mail-order service.....	\$70 for up to a 100-day supply
Most specialty items at a Plan Pharmacy.....	\$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.....	No charge
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.....	No charge
Individual outpatient substance use disorder evaluation and treatment.....	\$20 per visit
Group outpatient substance use disorder treatment.....	\$5 per visit

Benefit Summary*(continued)*

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	You Pay
Eyeglasses or contact lenses every 24 months.....	Amount in excess of \$150 Allowance
Hearing aid(s) every 36 months.....	Amount in excess of \$2,000 Allowance per aid
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
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i>	the Cost Share you would pay if the Services were to treat any other condition
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).