

Disclosure Form Part One

101500 UFCW UNIONS AND FOOD EMPLOYERS BENEFIT FUND

Home Region: Southern California

6/1/22 through 5/31/23

Principal benefits for Kaiser Permanente Traditional HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

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	\$25 per visit
Most Physician Specialist Visits.....	\$35 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	\$25 per visit
Most physical, occupational, and speech therapy	\$25 per visit

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures	\$150 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	\$500 per admission

Emergency Health Coverage

	You Pay
Emergency Department visits.....	\$100 per visit
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

Prescription Drug Coverage

	You Pay
The outpatient prescription drugs listed in the EOC in accord with our drug formulary guidelines at a Plan Pharmacy or through our mail-order service (most outpatient prescription drugs are not covered)	\$15 for up to a 30-day supply

Durable Medical Equipment (DME)

	You Pay
DME items as described in the EOC	No charge

Mental Health Services

	You Pay
Inpatient psychiatric hospitalization	\$500 per admission
Individual outpatient mental health evaluation and treatment	\$25 per visit
Group outpatient mental health treatment	\$12 per visit

Substance Use Disorder Treatment

	You Pay
Inpatient detoxification	\$500 per admission
Individual outpatient substance use disorder evaluation and treatment.....	\$25 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 aids every 36 months	Amount in excess of \$1,000 Allowance per aid
Skilled nursing facility care (up to 100 days per calendar year)	\$500 per admission

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Other	You Pay
Prosthetic and orthotic devices as described in the EOC.....	No charge
Diagnosis and treatment of infertility and artificial insemination	Not covered
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).