
Benefit Summary

101400 SOUTHERN CALIFORNIA DRUG BENEFIT FUND – Kaiser Clerks

**Principal Benefits for
Kaiser Permanente Traditional HMO Plan (6/1/21—5/31/22)****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	\$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.....	No charge
Most Physician Specialist Visits.....	No charge
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.....	No charge
Most physical, occupational, and speech therapy.....	No charge

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures.....	No charge
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

Emergency Health Coverage

	You Pay
Emergency Department visits.....	No charge

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
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service.....	\$5 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service.....	\$5 for up to a 100-day supply
Most specialty items at a Plan Pharmacy.....	\$5 for up to a 30-day supply

Durable Medical Equipment (DME)

	You Pay
Base DME items as described in the EOC (supplemental DME items are not covered).....	No charge

Mental Health Services

	You Pay
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment.....	No charge
Group outpatient mental health treatment.....	No charge

Substance Use Disorder Treatment

	You Pay
Inpatient detoxification.....	No charge
Individual outpatient substance use disorder evaluation and treatment.....	No charge
Group outpatient substance use disorder treatment.....	No charge

Home Health Services

	You Pay
Home health care (up to 100 visits per Accumulation Period).....	No charge

Other

	You Pay
Skilled nursing facility care (up to 100 days per benefit period).....	No charge

Benefit Summary*(continued)*

Other	You Pay
Base prosthetic and orthotic devices as described in the <i>EOC</i> (supplemental prosthetic and orthotic devices are not covered).....	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).