101400 SOUTHERN CALIFORNIA DRUG BENEFIT FUND – Platinum Plus

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
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
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

(continues)

Other	You Pay
Base prosthetic and orthotic devices as described in the *EOC* (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 *EOC*	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).