

## Disclosure Form

601044 FIRE DISTRICTS ASSOCIATION OF CA  
Home Region: Northern California

# Principal benefits for Kaiser Permanente Traditional HMO Plan

(1/1/20—12/31/20)

### 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 .....	\$15 per visit
Most Physician Specialist Visits .....	\$15 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 .....	\$15 per visit
Most physical, occupational, and speech therapy .....	\$15 per visit

### Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures .....	\$15 per procedure
Allergy injections (including allergy serum) .....	\$5 per visit
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 .....	\$100 per visit
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 .....	\$100 per trip

### 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 .....	\$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service ....	\$30 for up to a 100-day supply
Most specialty items at a Plan Pharmacy .....	20% Coinsurance (not to exceed \$100) 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 .....	No charge
Individual outpatient mental health evaluation and treatment .....	\$15 per visit
Group outpatient mental health treatment .....	\$7 per visit

### Substance Use Disorder Treatment

	You Pay
Inpatient detoxification .....	No charge
Individual outpatient substance use disorder evaluation and treatment .....	\$15 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

(continues)

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**Disclosure Form***(continued)*

<b>Other</b>	<b>You Pay</b>
Eyeglasses or contact lenses every 24 months .....	Amount in excess of \$150 Allowance
Hearing aid(s) every 36 months .....	Amount in excess of \$1,000 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
Diagnosis and treatment of infertility and artificial insemination.....	Not covered
Assisted reproductive technology ("ART") Services.....	Not covered
Hospice care .....	No charge

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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).