

**Benefit Summary**
**Informatica LLC**

Client ID #38555

**Principal Benefits for**
**Kaiser Permanente Traditional HMO Plan (1/1/19—12/31/19)**
**Accumulation Period**

The Accumulation Period for this plan is 1/1/19 through 12/31/19 (calendar year).

**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.....	\$20 per visit
Most Physician Specialist Visits.....	\$20 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 .....	\$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 injections (including allergy serum) .....	\$5 per visit
Most immunizations (including the vaccine) .....	No charge
Most X-rays and laboratory tests.....	\$10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the EOC.....	No charge
MRI, CT, and PET scans .....	\$50 per procedure
Covered individual health education counseling .....	No charge
Covered health education programs .....	No charge

**Hospitalization Services**
**You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	\$250 per admission
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**Emergency Health Coverage**
**You Pay**

Emergency Department visits.....	\$150 per visit
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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
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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 .....	\$10 for up to a 30-day supply
Most generic refills through our mail-order service.....	\$20 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.....	\$35 for up to a 30-day supply

**Durable Medical Equipment (DME)**
**You Pay**

DME items as described in the EOC.....	20% Coinsurance
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**Benefit Summary***(continued)*

<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization.....	\$250 per admission
Individual outpatient mental health evaluation and treatment .....	\$20 per visit
Group outpatient mental health treatment .....	\$10 per visit
<b>Substance Use Disorder Treatment</b>	<b>You Pay</b>
Inpatient detoxification .....	\$250 per admission
Individual outpatient substance use disorder evaluation and treatment.....	\$20 per visit
Group outpatient substance use disorder treatment .....	\$5 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per Accumulation Period) .....	No charge
<b>Chiropractic Coverage</b>	<b>You Pay</b>
Up to 30 visits per year with ASHP Provider – no referral required.....	\$10 per visit
<b>Other</b>	<b>You Pay</b>
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
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).

**For answers on benefit questions, verification of coverage, new member assistance, ID card replacement and to request a copy of your Evidence of Coverage, please contact our Member Services Call Center during the following business hours:**

**Monday to Friday – 7:00AM to 7:00PM  
Saturday & Sunday – 7:00AM to 3:00PM**

**English – 800.464.4000  
Spanish – 800.788.0616  
Chinese dialects – 800.757.7585**

**Senior Advantage and Medicare members – 800.443.0815**

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