Disclosure Form

100103 CITY OF RIVERSIDE - **HMO 30 PLAN**

Principal benefits for Kaiser Permanente Traditional Plan

(1/1/16—12/31/16)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Contact Center.

Accumulation Period

The Accumulation Period for this plan is 1/1/16 through 12/31/16 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year

Plan Deductible	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits for evaluations and treatment	$30 per visit
Most Specialty Care Visits for consultations, evaluations, and treatment	$30 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
Hearing exams	No charge
Urgent care consultations, evaluations, and treatment	$30 per visit
Most physical, occupational, and speech therapy	$30 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$30 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
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

Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit

Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	**You Pay**
Ambulance Services	$50 per trip

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	$20 for up to a 30-day supply
Most brand-name refills through our mail-order service	$40 for up to a 100-day supply

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Disclosure Form

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Durable Medical Equipment (DME)	You Pay
DME items that are essential health benefits in accord with our DME formulary guidelines	20% Coinsurance
DME items that are not essential health benefits in accord with our DME formulary guidelines	20% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$250 per admission
Individual outpatient mental health evaluation and treatment	$30 per visit
Group outpatient mental health treatment	$15 per visit

Chemical Dependency Services	You Pay
Inpatient detoxification	$250 per admission
Individual outpatient chemical dependency evaluation and treatment	$30 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge

Other	You Pay
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	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).