Benefit Summary

230179 CITY OF SAN JOSE

Principal Benefits for Kaiser Permanente Traditional HMO Plan (1/1/22—12/31/22)

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 January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

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.

Anounts Per Accumulation Period Self-Only Coverage (a Family of one Member) Each Mannbert in a Family of two or more Members Entite Family of two or more Members Plan Out-of-Pocket Maximum \$1,500 \$1,500 \$1,500 \$1,000 \$1,000 \$1,000 \$1,000 \$3,000 \$1,000 \$1,000 \$3			Family Coverage	Family Coverage	
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Inpatient psychiatric hospitalization \$100 per admission Individual outpatient mental health evaluation and treatment \$25 per visit Group outpatient mental health treatment \$12 per visit Substance Use Disorder Treatment You Pay	DME items as described in the EOC		No charge		
Individual outpatient mental health evaluation and treatment\$25 per visitGroup outpatient mental health treatment\$12 per visitSubstance Use Disorder TreatmentYou Pay	Mental Health Services		You Pay		
Individual outpatient mental health evaluation and treatment\$25 per visitGroup outpatient mental health treatment\$12 per visitSubstance Use Disorder TreatmentYou Pay	Inpatient psychiatric hospitalization		\$100 per admission		
Group outpatient mental health treatment \$12 per visit Substance Use Disorder Treatment You Pay					
	Substance Use Disorder Treatment		You Pay		
Individual outpatient substance use disorder evaluation and treatment \$25 per visit					
Group outpatient substance use disorder treatment					

Benefit Summary	(continued)
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	You Pay
Hearing aids every 36 months	Amount in excess of \$500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the EOC	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient	
procedures or laboratory tests) as described in the EOC	
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).