

## Health Plan Benefits and Coverage Matrix (\$30/\$3,000 Deductible Plan with HSA Option)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

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 your Home Region Service Area, except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, visiting Member care, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

"Kaiser Permanente HSA-Qualified Deductible HMO Plan" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in the *EOC* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

### Annual Out-of-Pocket Maximum

You will not pay any more Cost Sharing during a calendar year if the Copayments, Coinsurance, and Deductible amounts you pay for Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member) .....	\$5,950 per calendar year
For any one Member in a Family of two or more Members .....	\$5,950 per calendar year
For an entire Family of two or more Members .....	\$11,900 per calendar year

### Deductible for all Services except certain preventive Services as specified below

You must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:

For self-only enrollment (a Family of one Member) .....	\$3,000 per calendar year
For any one Member in a Family of two or more Members .....	\$3,000 per calendar year
For an entire Family of two or more Members .....	\$6,000 per calendar year

Note: The Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.

### Lifetime Maximum

None

### Professional Services (Plan Provider office visits)

You Pay

Most primary and specialty care consultations, exams, and treatment .....	\$30 per visit after Deductible
Routine physical maintenance exams .....	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months).....	No charge (Deductible doesn't apply)
Family planning counseling.....	\$30 per visit after Deductible
Scheduled prenatal care exams .....	No charge (Deductible doesn't apply)
Eye exams for refraction .....	\$30 per visit after Deductible
Hearing exams .....	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment .....	\$30 per visit after Deductible
Physical, occupational, and speech therapy.....	\$30 per visit after Deductible

### Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures .....	30% Coinsurance after Deductible
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<b>Outpatient Services</b>		<b>You Pay</b>
Allergy injections (including allergy serum).....		\$5 per visit after Deductible
Most immunizations (including the vaccine) .....		No charge (Deductible doesn't apply)
Most X-rays and laboratory tests .....		\$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i> ...		No charge (Deductible doesn't apply)
MRI, most CT, and PET scans .....		\$50 per procedure after Deductible
Health education:		
Covered individual health education counseling .....		No charge (Deductible doesn't apply)
Covered health educational programs .....		No charge (Deductible doesn't apply)
<b>Hospitalization Services</b>		<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....		30% Coinsurance after Deductible
<b>Emergency Health Coverage</b>		<b>You Pay</b>
Emergency Department visits .....		30% Coinsurance after Deductible
<b>Ambulance Services</b>		<b>You Pay</b>
Ambulance Services .....		\$100 per trip after Deductible
<b>Prescription Drug Coverage</b>		<b>You Pay</b>
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, \$20 for a 31- to 60-day supply, or \$30 for a 61- to 100-day supply after Deductible
Most generic refills through our mail-order service .....		\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply after Deductible
Most brand-name items at a Plan Pharmacy.....		\$30 for up to a 30-day supply, \$60 for a 31- to 60-day supply, or \$90 for a 61- to 100-day supply after Deductible
Most brand-name refills through our mail-order service .....		\$30 for up to a 30-day supply or \$60 for a 31- to 100-day supply after Deductible
<b>Durable Medical Equipment</b>		<b>You Pay</b>
The durable medical equipment items for home use listed in the <i>EOC</i> in accord with our durable medical equipment formulary guidelines (most durable medical equipment is <b>not covered</b> ) .....		20% Coinsurance after Deductible
<b>Mental Health Services</b>		<b>You Pay</b>
Inpatient psychiatric hospitalization .....		30% Coinsurance after Deductible
Individual outpatient mental health evaluation and treatment.....		\$30 per individual visit after Deductible
Group outpatient mental health treatment .....		\$15 per group visit after Deductible
<b>Chemical Dependency Services</b>		<b>You Pay</b>
Inpatient detoxification .....		30% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment .....		\$30 per visit after Deductible
Group outpatient chemical dependency treatment.....		\$5 per visit after Deductible

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year) .....	No charge after Deductible
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period) .....	30% Coinsurance after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the <i>EOC</i> (most external prosthetic and orthotic devices are <b>not covered</b> ) .....	No charge after Deductible
Hospice care .....	No charge after Deductible

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).