

Disclosure Form

104301 COUNTY OF SAN DIEGO
DHMO HSA 7430
Member Services 800-464-4000

Principal Benefits for

Kaiser Permanente HSA-Qualified Deductible HMO Plan (1/1/17—12/31/17)

"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. For a complete explanation, please refer to the *EOC*.

Accumulation Period

The Accumulation Period for this plan is 1/1/17 through 12/31/17 (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.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

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

Amounts Per Accumulation Period	Self-Only Coverage (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	\$3,000	\$3,000	\$6,000
Plan Deductible	\$1,500	\$2,600	\$3,000
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)

You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits	10% Coinsurance after Plan Deductible
Most Physician Specialist Visits	10% Coinsurance after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	10% Coinsurance (Plan Deductible doesn't apply)
Hearing exams	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	10% Coinsurance after Plan Deductible
Most physical, occupational, and speech therapy	10% Coinsurance after Plan Deductible

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	10% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	10% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	10% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i>	No charge (Plan Deductible doesn't apply)
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (Plan Deductible doesn't apply)

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	10% Coinsurance after Plan Deductible
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Emergency Health Coverage

You Pay

Emergency Department visits	10% Coinsurance after Plan Deductible
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Ambulance Services

You Pay

Ambulance Services	10% Coinsurance after Plan Deductible
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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 after Plan Deductible
Most generic refills through our mail-order service	\$20 for up to a 100-day supply after Plan Deductible
Most brand-name items at a Plan Pharmacy	\$30 for up to a 30-day supply after Plan Deductible
Most brand-name refills through our mail-order service	\$60 for up to a 100-day supply after Plan Deductible

Disclosure Form*(continued)*

Most specialty items at a Plan Pharmacy \$30 for up to a 30-day supply after Plan Deductible

Durable Medical Equipment (DME) You Pay

DME items that are essential health benefits in accord with our DME formulary guidelines 10% Coinsurance after Plan Deductible

DME items that are not essential health benefits in accord with our DME formulary guidelines up to a \$2,500 benefit limit per Accumulation Period as described in the *EOC*..... 10% Coinsurance after Plan Deductible

Mental Health Services You Pay

Inpatient psychiatric hospitalization..... 10% Coinsurance after Plan Deductible

Individual outpatient mental health evaluation and treatment 10% Coinsurance after Plan Deductible

Group outpatient mental health treatment..... 10% Coinsurance after Plan Deductible

Chemical Dependency Services You Pay

Inpatient detoxification 10% Coinsurance after Plan Deductible

Individual outpatient chemical dependency evaluation and treatment..... 10% Coinsurance after Plan Deductible

Group outpatient chemical dependency treatment 10% Coinsurance after Plan Deductible

Home Health Services You Pay

Home health care (up to 100 visits per Accumulation Period) No charge after Plan Deductible

Other You Pay

Skilled nursing facility care (up to 100 days per benefit period)..... 10% Coinsurance after Plan Deductible

Prosthetic and orthotic devices No charge after Plan Deductible

Hospice care No charge after Plan Deductible

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).