

Proposed Benefit Summary



Customer Name: County of San Diego
Customer ID: 104301

Benefit Plan 4310
HC2 TYPE HSA2; \$1500DED;10%OP
;10%IP; \$30/10RX; MOI

Principal Benefits for
Kaiser Permanente HSA-Qualified Deductible HMO 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, 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.

Out-of-Pocket Maximum

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

You will not pay any more Cost Share during the calendar year if the Copayments and Coinsurance you pay, plus all your payments toward the Plan Deductible, add up to one of the following amounts:

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

Plan Deductible

For Services subject to the Plan Deductible, you must pay Charges for Services you receive in the calendar year until you reach one of the following Plan Deductible amounts:

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

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.

Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

Table with 2 columns: Service description and You Pay. Rows include Primary Care Visits, Specialty Care Visits, Routine physical maintenance exams, Well-child preventive exams, Family planning counseling, Scheduled prenatal care exams, Routine eye exams, Hearing exams, Urgent care consultations, and Most physical, occupational, and speech therapy.

Outpatient Services

You Pay

Table with 2 columns: Service description and You Pay. Rows include Outpatient surgery, Allergy injections, Most immunizations, Most X-rays and laboratory tests, Preventive X-rays, Covered individual health education counseling, and Covered health education programs.

Hospitalization Services

You Pay

Table with 2 columns: Service description and You Pay. Row: Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.

Emergency Health Coverage

You Pay

Table with 2 columns: Service description and You Pay. Row: Emergency Department visits.

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**Proposed Benefit Summary***(continued)*

<b>Ambulance Services</b>	<b>You Pay</b>
Ambulance Services .....	10% Coinsurance after Plan 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 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
<b>Durable Medical Equipment (DME)</b>	<b>You Pay</b>
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 calendar year as described in the <i>EOC</i> .....	10% Coinsurance after Plan Deductible
<b>Mental Health Services</b>	<b>You Pay</b>
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
<b>Chemical Dependency Services</b>	<b>You Pay</b>
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
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per calendar year) .....	No charge after Plan Deductible
<b>Other</b>	<b>You Pay</b>
Skilled nursing facility care (up to 100 days per benefit period) .....	10% Coinsurance after Plan Deductible
Ostomy and urological supplies .....	No charge after Plan Deductible
Prosthetic and orthotic devices that are essential health benefits .....	No charge after Plan Deductible
Prosthetic and orthotic devices that are not essential health benefits .....	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).