KAISER PERMANENTE® thrive

FINAL Benefit Summary

603950 COUNTY OF MARIN - Extra Hires Only

Principal Benefits for Kaiser Permanente HSA-Qualified Deductible HMO Plan 7423 (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 Northern 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. For information about who is eligible to contribute to an HSA, refer to your Group's enrollment materials or consult with your tax advisor.

Accumulation Period

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

Plan Out-of-Pocket Maximum

You will not pay any more Cost Share for the rest of 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)	$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

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)	$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 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.

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialty Visits	20% Coinsurance after Plan Deductible
Most Physician Specialist Visits	20% 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 for Pediatric Members	20% Coinsurance after Plan Deductible
Routine eye exams with a Plan Optometrist for Adult Members	20% Coinsurance (Plan Deductible doesn't apply)
Hearing exams	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	20% Coinsurance after Plan Deductible
Most physical, occupational, and speech therapy	20% Coinsurance after Plan Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	20% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	20% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	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	20% Coinsurance after Plan Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	20% Coinsurance after Plan Deductible

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(continued)

Ambulance Services	You Pay
Ambulance Services	20% Coinsurance after Plan Deductible

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

Durable Medical Equipment (DME)	You Pay
DME items in accord with our DME formulary guidelines	20% Coinsurance after Plan Deductible

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	20% Coinsurance after Plan Deductible
Group outpatient mental health treatment	20% Coinsurance after Plan Deductible

Chemical Dependency Services	You Pay
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	20% Coinsurance after Plan Deductible
Group outpatient chemical dependency treatment	20% Coinsurance after Plan Deductible

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

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	20% 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).

For answers on benefit questions, verification of coverage, new member assistance, ID card replacement and to request a copy of your Evidence of Coverage, please contact our Member Services Call Center during the following business hours:

Monday to Friday – 7:00AM to 7:00PM
Saturday & Sunday – 7:00AM to 3:00PM

English, Tagalog, and Vietnamese – 800.464.4000
Spanish – 800.788.0616
Chinese dialects – 800.757.7585

You may also visit us at www.kp.org