Benefit Summary

KAISER PERMANENTE

Customer Name: Solano Napa
Customer ID: 16968 & 14152

Benefit Plan 4415
HC2 TYPE XP8 HRA;$1500D;$20 O P;20%IP;$30/10 RX MOI

Principal Benefits for Kaiser Permanente Deductible HMO Plan with HRA (09/01/2013 — 05/31/2014)

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, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

"Kaiser Permanente Deductible Plan with HRA" is a health benefit plan that is designed for Members with an employer-sponsored HRA (Health Reimbursement Arrangement). You may use the funds in your HRA to pay Copayments, Coinsurance, and Deductibles. Your Group will give you information about your HRA, including the amount of your HRA funds and how to access your funds.

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to one of the following 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

Deductible for Certain Services	
For Services subject to the Deductible, 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)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$20 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	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$20 per visit after Deductible
Physical, occupational, and speech therapy	$20 per visit after Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Deductible
Allergy injections (including allergy serum)	No charge 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 *EOC*	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 education programs	No charge (Deductible doesn't apply)

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Deductible

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

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible

(continues)

Benefit Summary *(continued)*

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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Deductible doesn't apply)
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 (Deductible doesn't apply)
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 (Deductible doesn't apply)
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 (Deductible doesn't apply)
Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance after Deductible
Individual outpatient mental health evaluation and treatment	$20 per visit after Deductible
Group outpatient mental health treatment	$10 per visit after Deductible
Chemical Dependency Services	**You Pay**
Inpatient detoxification	20% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment	$20 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 (Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance after Deductible
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge (Deductible doesn't apply)
Chiropractic Services	$10 per visit up to 30 vists per calendar year
All Services related to covered infertility treatment	50% Coinsurance (Deductible doesn't apply)
Hospice care	No charge (Deductible doesn't apply)

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).