KAISER PERMANENTE®

*** PLEASE NOTE THE BENEFIT SUMMARY FOR THIS PLAN DOES NOT REFLECT THE MENTAL HEALTH PARITY ACT. AN UPDATED BENEFIT SUMMARY WILL BE GIVEN WHEN AVAILABLE.**

Benefit Plan 2480/2471
TYPE HSA; $1500 DED;$0 OUTP;$ 0 INPT; $0 RX

Disclosure Form Part One — Principal Benefits for Kaiser Permanente $1,500 Deductible Plan with HSA Option

The Services described below are covered only if all 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 Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

"Kaiser Permanente $1,500 Deductible Plan with HSA Option" 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 after the Copayments, Coinsurance, and Deductible amounts you pay for Services add up to one of the following amounts:	
For self-only enrollment (a Family Unit of one Member)	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 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 Unit of one Member)	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 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**
Primary and specialty care visits (includes routine and Urgent Care appointments)	No charge after Deductible
Routine preventive physical exams	No charge (Deductible doesn't apply)
Well-child preventive care visits (0–23 months)	No charge (Deductible doesn't apply)
Family planning visits	No charge after Deductible
Scheduled prenatal care	No charge (Deductible doesn't apply)
Routine preventive refraction exams	No charge after Deductible
Routine preventive hearing tests	No charge after Deductible
Physical, occupational, and speech therapy visits	No charge after Deductible
Outpatient Services	**You Pay**
Outpatient surgery	No charge after Deductible
Allergy injection visits	No charge after Deductible
Allergy testing visits	No charge after Deductible
Vaccines (immunizations)	No charge (Deductible doesn't apply)
X-rays and lab tests	No charge after Deductible (except the Deductible doesn't apply to preventive screenings as described in the *EOC*)
Health education:	
Individual visits	No charge after Deductible
Group educational programs	No charge after Deductible (except the Deductible doesn't apply to tobacco-cessation programs)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge after Deductible

continued

Emergency Health Coverage	**You Pay**
Emergency Department visits	No charge after Deductible
Ambulance Services	**You Pay**
Ambulance Services	No charge after Deductible
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order program	No charge for up to a 100-day supply after Deductible
Durable Medical Equipment (DME)	**You Pay**
Most covered DME for home use in accord with our DME formulary guidelines up to a $2,500 calendar year benefit limit as described in the *EOC*	No charge after Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric care (up to 30 days per calendar year)	No charge after Deductible
Outpatient visits:	
Up to a total of 20 individual and group therapy visits per calendar year	No charge after Deductible
Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year	No charge per group therapy visit after Deductible
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *EOC*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge after Deductible
Outpatient individual therapy visits	No charge after Deductible
Outpatient group therapy visits	No charge after Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	No charge after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 two-hour visits per calendar year)	No charge after Deductible
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	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).