

Proposed Benefit Summary

16968 & 14152SOLANO-NAPA COUNTIES ELECT H&W TRUST FUND – Actives & E. Retirees

Principal Benefits for Kaiser Permanente Deductible HMO Plan with HRA 4415(6/1/14—5/31/15)

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.

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services, 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 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

Plan Deductible for Certain Services

For Services subject to the Plan Deductible, you must pay Charges for Services you receive in a 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 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, evaluations, and treatment	\$20 per visit 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)
Eye exams for refraction	No charge (Plan Deductible doesn't apply)
Hearing exams	No charge (Plan Deductible doesn't apply)
Urgent care consultations, exams, and treatment.....	\$20 per visit after Plan Deductible
Most physical, occupational, and speech therapy.....	\$20 per visit after Plan Deductible

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures.....	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge after Plan Deductible
Most immunizations (including the vaccine).....	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests.....	\$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i>	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	\$50 per procedure after Plan Deductible
Health education:	
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
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Emergency Health Coverage

You Pay

Emergency Department visits	20% Coinsurance after Plan Deductible
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Ambulance Services

You Pay

Ambulance Services	\$150 per trip after Plan Deductible
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Proposed Benefit Summary

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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 (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	\$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	\$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service.....	\$60 for up to a 100-day supply (Plan 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 (Plan Deductible doesn't apply)

Mental Health Services

	You Pay
Inpatient psychiatric hospitalization.....	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment.....	\$20 per visit after Plan Deductible
Group outpatient mental health treatment.....	\$10 per visit after Plan Deductible

Chemical Dependency Services

	You Pay
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment.....	\$20 per visit after Plan Deductible
Group outpatient chemical dependency treatment	\$5 per visit after Plan Deductible

Home Health Services

	You Pay
Home health care (up to 100 visits per calendar year).....	No charge (Plan Deductible doesn't apply)

Other

	You Pay
Skilled nursing facility care (up to 100 days per benefit period).....	20% Coinsurance after Plan Deductible
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge (Plan Deductible doesn't apply)
All Services related to covered infertility treatment	50% Coinsurance (Plan Deductible doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)

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).