HDIEET PLAN 5

Principal Benefits for Kaiser Permanente Deductible HMO Plan (7/1/17—6/30/18)

Accumulation Period

The Accumulation Period for this plan is 1/1/17 through 12/31/17 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.
For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$6,000	$6,000	$12,000
Plan Deductible	$4,500	$4,500	$9,000
Drug Deductible	$250	$250	Not applicable

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$50 per visit after Plan Deductible
Most Physician Specialist Visits	$50 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)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$50 per visit after Plan Deductible
Most physical, occupational, and speech therapy	$50 per visit after Plan Deductible

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	40% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	$15 per visit after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	40% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	$150 per procedure after Plan Deductible
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	40% Coinsurance after Plan Deductible

Emergency Health Coverage	You Pay
Emergency Department visits	$250 per visit after Plan Deductible

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	40% 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	$15 for up to a 30-day supply (Drug Deductible doesn't apply)
Most generic refills through our mail-order service	$30 for up to a 100-day supply (Drug Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply after Drug Deductible
Most brand-name refills through our mail-order service	$70 for up to a 100-day supply after Drug Deductible
Most specialty items at a Plan Pharmacy	30% Coinsurance (not to exceed $150) for up to a 30-day supply after Drug Deductible

(continues)

Benefit Summary *(continued)*

Durable Medical Equipment (DME)	You Pay
DME items that are essential health benefits in accord with our DME formulary guidelines	40% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	40% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$50 per visit after Plan Deductible
Group outpatient mental health treatment	$25 per visit after Plan Deductible
Chemical Dependency Services	**You Pay**
Inpatient detoxification	40% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	$50 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 Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	40% Coinsurance after Plan Deductible
Prosthetic and orthotic devices that are essential health benefits	No charge (Plan Deductible doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)
Chiropractic Benefit (30 visits per calendar year)	$10 per visit

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).