1880 CITY OF SACRAMENTO
Account Based Health Plan

Principal Benefits for Kaiser Permanente HSA-Qualified Deductible HMO Plan (1/1/14—12/31/14)

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.

Annual Out-of-Pocket Maximum	
You will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay, and 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 an entire Family of two or more Members	$6,000 per calendar year

Plan Deductible for Most 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)	$2,000 per calendar year
For an entire Family of two or more Members	$4,000 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.	
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, evaluations, and treatment	$30 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	$30 per visit after Plan Deductible
Hearing exams	No charge (Plan Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$30 per visit after Plan Deductible
Most physical, occupational, and speech therapy	$30 per visit after Plan Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$150 per procedure after Plan Deductible
Allergy injections (including allergy serum)	$5 per visit 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 *EOC*	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	$250 per admission after Plan Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit after Plan Deductible
Note: After you meet the Plan Deductible, this Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	

Ambulance Services	**You Pay**
Ambulance Services	$100 per trip after Plan Deductible

(continues)

Proposed 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 after Plan Deductible
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 after Plan Deductible
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 after Plan Deductible
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 after Plan Deductible

Durable Medical Equipment	You Pay
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance after Plan Deductible

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$250 per admission after Plan Deductible
Individual outpatient mental health evaluation and treatment	$30 per visit after Plan Deductible
Group outpatient mental health treatment	$15 per visit after Plan Deductible

Chemical Dependency Services	You Pay
Inpatient detoxification	$250 per admission after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	$30 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 after Plan Deductible

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	$250 per admission after Plan Deductible
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	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).