

Benefit Summary

887 CITY OF SAN JOSE

Principal Benefits for Kaiser Permanente HSA-Qualified High Deductible Health Plan (“HDHP”) HMO (1/1/21— 12/31/21)

“Kaiser Permanente HSA-Qualified High Deductible Health Plan (“HDHP”) HMO” is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the EOC.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

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.

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.

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	\$5,950	\$5,950	\$11,900
Plan Deductible	\$3,000	\$3,000	\$6,000
Drug Deductible	Not applicable	Not applicable	Not applicable

Professional Services (Plan Provider office visits)

	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits.....	30% Coinsurance after Plan Deductible
Most Physician Specialist Visits.....	30% Coinsurance 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.....	30% Coinsurance (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment.....	30% Coinsurance after Plan Deductible
Most physical, occupational, and speech therapy.....	30% Coinsurance after Plan Deductible

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures.....	30% Coinsurance after Plan Deductible
Allergy antigens (including administration).....	30% Coinsurance after Plan Deductible
Most immunizations (including the vaccine).....	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests.....	30% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the EOC.....	No charge (Plan Deductible doesn't apply)

Hospitalization Services

	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	30% Coinsurance after Plan Deductible

Emergency Health Coverage

	You Pay
Emergency Department visits.....	30% Coinsurance after Plan Deductible

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see “Hospitalization Services” for inpatient Cost Share)

Ambulance Services

	You Pay
Ambulance Services.....	30% 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.....	\$10 for up to a 30-day supply after Plan Deductible
Most generic refills through our mail-order service.....	\$20 for up to a 100-day supply after Plan Deductible
Most brand-name items at a Plan Pharmacy.....	\$30 for up to a 30-day supply after Plan Deductible
Most brand-name refills through our mail-order service.....	\$60 for up to a 100-day supply after Plan Deductible
Most specialty items at a Plan Pharmacy.....	\$30 for up to a 30-day supply after Plan Deductible

Durable Medical Equipment (DME)

	You Pay
DME items as described in the EOC.....	30% Coinsurance after Plan Deductible

Mental Health Services

	You Pay
Inpatient psychiatric hospitalization.....	30% Coinsurance after Plan Deductible

Benefit Summary

(continued)

Mental Health Services	You Pay
Individual outpatient mental health evaluation and treatment.....	30% Coinsurance after Plan Deductible
Group outpatient mental health treatment	30% Coinsurance after Plan Deductible
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	30% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	30% Coinsurance after Plan Deductible
Group outpatient substance use disorder treatment.....	30% Coinsurance after Plan Deductible
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge after Plan Deductible
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period).....	30% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge after Plan Deductible
Diagnosis and treatment of infertility and artificial insemination.....	Not covered
Assisted reproductive technology ("ART") Services	Not covered
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).