Disclosure Form

2016 REEP/Minimum Value Plan with Chiropractic

Principal benefits for Kaiser Permanente Deductible HMO Plan

(7/1/16—6/30/17)

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 Southern 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

Accumulation Period

The Accumulation Period for this plan is 1/1/16 through 12/31/16 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the 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)	$6,000 per calendar year
For any one Member in a Family of two or more Members	$6,000 per calendar year
For an entire Family of two or more Members	$12,000 per calendar year

Drug Deductible

For Services subject to the Drug Deductible, you must pay Charges for Services you receive in the calendar year until you reach one of the following Drug Deductible amounts:

For self-only enrollment (a Family of one Member)	$250 per calendar year
For any one Member in a Family of two or more Members	$250 per calendar year

Plan Deductible

For Services subject to the Plan Deductible, you must pay Charges for Services you receive in the calendar year until you reach one of the following Plan Deductible amounts:

For self-only enrollment (a Family of one Member)	$4,500 per calendar year
For any one Member in a Family of two or more Members	$4,500 per calendar year
For an entire Family of two or more Members	$9,000 per calendar year

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)
Hearing exams	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: 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).

(continues)

Disclosure Form *(continued)*

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 (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$30 for up to a 100-day supply (Plan 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

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 calendar year)	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 Care - up to 30 visits per 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).