Proposed Benefit Summary

KAISER PERMANENTE®

Customer Name: **American Airlines**
Customer ID: **California**

DHMO Benefit Summary
HC3: TYPE XD19; $250 DED
$20 OP; 20 IP; $30/$15 RX

Principal Benefits for Kaiser Permanente Deductible HMO Plan (1/1/17—12/31/17)

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 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

Accumulation Period

The Accumulation Period for this plan is 1/1/17 through 12/31/17

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)	$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 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)	$250 per calendar year
For any one Member in a Family of two or more Members	$250 per calendar year
For an entire Family of two or more Members	$500 per calendar year

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits for evaluations and treatment	$20 per visit (Plan Deductible doesn't apply)
Most Specialty Care Visits for consultations, evaluations, and treatment	$40 per visit (Plan Deductible doesn't apply)
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	$20 per visit (Plan Deductible doesn't apply)
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 ***EOC***	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	$50 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	20% Coinsurance after Plan Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	20% Coinsurance after Plan Deductible

Ambulance Services	**You Pay**
Ambulance Services	20% Coinsurance after Plan Deductible

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Proposed Benefit Summary *(continued)*

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines at a Plan Pharmacy or through our mail-order service:	
Most generic items	$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	$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 (DME)	**You Pay**
DME items that are essential health benefits in accord with our DME formulary guidelines	20% Coinsurance (Plan Deductible doesn't apply)
DME items that are not essential health benefits in accord with our DME 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 (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Plan Deductible doesn't apply)
Chemical Dependency Services	**You Pay**
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient chemical dependency treatment	$10 per visit (Plan Deductible doesn't apply)
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
Prosthetic and orthotic devices	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)
Chiropractic care (up to 20 visits per calendar year)	$15 per visit (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).