

**Principal Benefits for Kaiser Permanente Traditional Plan (1/1/11—12/31/11)**

The Services described below are covered only if all 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 or 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 Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

**Annual Out-of-Pocket Maximum for Certain Services**

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member).....	\$1,500 per calendar year
For any one Member in a Family of two or more Members .....	\$1,500 per calendar year
For an entire Family of two or more Members .....	\$3,000 per calendar year

**Deductible or Lifetime Maximum** **None**

**Professional Services (Plan Provider office visits)** **You Pay**

Routine preventive care:

Physical exams .....	No charge
Well-child visits (through age 23 months) .....	No charge
Family planning visits .....	No charge
Scheduled prenatal care visits and first postpartum visit .....	No charge
Eye exams for refraction .....	No charge
Hearing tests .....	No charge
Flexible sigmoidoscopies .....	No charge
Colonoscopies .....	No charge

Primary and specialty care visits .....	\$15 per visit
Urgent care visits.....	\$15 per visit
Physical, occupational, and speech therapy .....	\$15 per visit

**Outpatient Services** **You Pay**

Outpatient surgery and certain other outpatient procedures .....	\$15 per procedure
Allergy injection visits .....	No charge
Allergy testing visits .....	\$15 per visit
Most vaccines (immunizations) .....	No charge
X-rays and lab tests.....	No charge
Health education:	
Individual visits .....	No charge
Group educational programs.....	No charge

**Hospitalization Services** **You Pay**

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs .....	\$100 per admission
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**Emergency Health Coverage** **You Pay**

Emergency Department visits .....	\$100 per visit
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Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing)

**Ambulance Services** **You Pay**

Ambulance Services .....	\$50 per trip
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**Prescription Drug Coverage** **You Pay**

Most covered outpatient items in accord with our drug formulary guidelines:

Generic items from 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
Generic refills from our mail-order service .....	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply
Brand-name items from a Plan Pharmacy .....	\$25 for up to a 30-day supply, \$50 for a 31- to 60-day supply, or \$75 for a 61- to 100-day supply
Brand-name refills from our mail-order service .....	\$25 for up to a 30-day supply or \$50 for a 31- to 100-day supply

continued

<b>Durable Medical Equipment</b>	<b>You Pay</b>
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines .....	20% Coinsurance
<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs.....	\$100 per admission
Outpatient individual and group visits.....	\$15 per individual visit \$7 per group visit
<b>Chemical Dependency Services</b>	<b>You Pay</b>
Inpatient detoxification.....	\$100 per admission
Outpatient individual visits.....	\$15 per visit
Outpatient group visits.....	\$5 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per calendar year) .....	No charge
<b>Other</b>	<b>You Pay</b>
Skilled nursing facility care (up to 100 days per benefit period) .....	\$100 per admission
All covered Services related to infertility treatment .....	50% Coinsurance
Hospice care .....	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).