

## Disclosure Form Part One — Principal Benefits for Kaiser Permanente Traditional Plan (1/1/08—12/31/08)

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 (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

<b>Annual Out-of-Pocket Maximum for Certain Services</b>	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year after the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family Unit of one Member)	\$1,500 per calendar year
For any one Member in a Family Unit of two or more Members	\$1,500 per calendar year
For an entire Family Unit of two or more Members	\$3,000 per calendar year
<b>Deductible or Lifetime Maximum</b>	None
<b>Professional Services (Plan Provider office visits)</b>	<b>You Pay</b>
Primary and specialty care visits (includes routine and Urgent Care appointments)	\$15 per visit
Routine preventive physical exams	\$15 per visit
Well-child preventive care visits (0–23 months)	\$5 per visit
Family planning visits	\$15 per visit
Scheduled prenatal care and first postpartum visit	\$5 per visit
Routine preventive refraction exams	\$15 per visit
Routine preventive hearing tests	\$15 per visit
Physical, occupational, and speech therapy visits	\$15 per visit
<b>Outpatient Services</b>	<b>You Pay</b>
Outpatient surgery	\$15 per procedure
Allergy injection visits	No charge
Allergy testing visits	\$15 per visit
Vaccines (immunizations)	No charge
X-rays and lab tests	No charge
Health education:	
Individual visits	\$15 per visit
Group educational programs	No charge
<b>Hospitalization Services</b>	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge
<b>Emergency Health Coverage</b>	<b>You Pay</b>
Emergency Department visits	\$35 per visit (does not apply if admitted directly to the hospital as an inpatient)
<b>Ambulance Services</b>	<b>You Pay</b>
Ambulance Services	No charge
<b>Prescription Drug Coverage</b>	<b>You Pay</b>
Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order program:	
Generic items	\$5 for up to a 100-day supply
Brand-name items	\$15 for up to a 100-day supply
<b>Durable Medical Equipment (DME)</b>	<b>You Pay</b>
Covered DME for home use in accord with our DME formulary guidelines	No charge

continued

<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric care (up to 30 days per calendar year)	No charge
Outpatient visits:	
Up to a total of 20 individual and group visits per calendar year	\$15 per individual visit \$7 per group visit
Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year	\$7 per group visit
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the EOC.	
<b>Chemical Dependency Services</b>	<b>You Pay</b>
Inpatient detoxification	No charge
Outpatient individual visits	\$15 per visit
Outpatient group visits	\$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission
<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>
Eyewear purchased from Plan Optical Sales Offices every 24 months	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
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).