

**Proposed Benefit Summary  
HDIT/Kaiser Permanente  
STANDARD PLAN**

**Principal Benefits for Kaiser Permanente Traditional Plan (7/1/10—6/30/11)**

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 (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 .....	\$10 per visit
Well-child visits (through age 23 months) .....	No charge
Family planning visits .....	\$10 per visit
Scheduled prenatal care visits and first postpartum visit .....	No charge
Eye refraction exams.....	\$10 per visit
Hearing tests .....	\$10 per visit
Primary and specialty care visits .....	\$10 per visit
Urgent care visits .....	\$10 per visit
Physical, occupational, and speech therapy .....	\$10 per visit

**Outpatient Services**

**You Pay**

Outpatient surgery and certain other outpatient procedures .....	\$10 per procedure
Allergy, injection visits .....	\$5 per visit
Allergy, testing visits .....	\$10 per visit
Vaccines (immunizations) .....	No charge
X-rays and lab tests.....	No charge
Health education:	
Individual visits .....	\$10 per visit
Group educational programs.....	No charge

**Hospitalization Services**

**You Pay**

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs .....	No charge
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**Emergency Health Coverage**

**You Pay**

Emergency Department visits .....	\$100 per visit (does not apply if admitted directly to the hospital as an inpatient)
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**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 items from our mail-order service .....	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply

<b>Prescription Drug Coverage</b>		<b>You Pay</b>
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
<b>Durable Medical Equipment (DME)</b>		<b>You Pay</b>
Covered DME for home use in accord with our DME formulary guidelines .....		No charge
<b>Mental Health Services</b>		<b>You Pay</b>
Inpatient psychiatric hospitalization .....		No charge
Outpatient visits:		
Individual and group visits per calendar year .....		\$10 per individual visit \$5 per group visit
<b>Chemical Dependency Services</b>		<b>You Pay</b>
Inpatient detoxification.....		No charge
Outpatient individual visits.....		\$10 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>
All covered Services related to infertility treatment .....		50% Coinsurance
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).