

## Disclosure Form Part One — Principal Benefits for Kaiser Permanente Deductible Plan (11/1/08—10/31/09)

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, plus all your Deductible payments, add up to one of the following amounts:

For self-only enrollment (a Family Unit of one Member) .....	\$3,000 per calendar year
For any one Member in a Family Unit of two or more Members .....	\$3,000 per calendar year
For an entire Family Unit of two or more Members .....	\$6,000 per calendar year

### Deductible for Certain Services as specified below

You must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:

For self-only enrollment (a Family Unit of one Member) .....	\$1,000 per calendar year
For any one Member in a Family Unit of two or more Members .....	\$1,000 per calendar year
For an entire Family Unit of two or more Members .....	\$2,000 per calendar year

### Lifetime Maximum

None

### Professional Services (Plan Provider office visits)

You Pay

Primary and specialty care visits (includes routine and Urgent Care appointments) .....	\$20 per visit (Deductible doesn't apply)
Routine preventive physical exams .....	\$20 per visit (Deductible doesn't apply)
Well-child preventive care visits (through age 23 months) .....	\$10 per visit (Deductible doesn't apply)
Family planning visits .....	\$20 per visit (Deductible doesn't apply)
Scheduled prenatal care visits and first postpartum visit .....	\$10 per visit (Deductible doesn't apply)
Routine preventive refraction exams .....	\$20 per visit (Deductible doesn't apply)
Routine preventive hearing tests .....	\$20 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy visits .....	\$20 per visit (Deductible doesn't apply)

### Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures .....	20% Coinsurance after Deductible
Allergy injection visits .....	No charge (Deductible doesn't apply)
Allergy testing visits .....	\$20 per visit (Deductible doesn't apply)
Vaccines (immunizations) .....	No charge (Deductible doesn't apply)
X-rays and lab tests .....	\$10 per encounter (Deductible doesn't apply)
MRI, CT and PET .....	\$50 per procedure (Deductible doesn't apply)
Health education:	
Individual visits .....	\$20 per visit (Deductible doesn't apply)
Group educational programs .....	No charge (Deductible doesn't apply)

### Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs .....	20% Coinsurance after Deductible
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### Emergency Health Coverage

You Pay

Emergency Department visits .....	20% Coinsurance after Deductible
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### Ambulance Services

You Pay

Ambulance Services .....	\$150 per trip (Deductible doesn't apply)
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continued

<b>Prescription Drug Coverage</b>		<b>You Pay</b>
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 (Deductible doesn't apply)
Generic refills from our mail-order service .....		\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply (Deductible doesn't apply)
Brand-name items from a Plan Pharmacy .....		\$30 for up to a 30-day supply, \$60 for a 31- to 60-day supply, or \$90 for a 61- to 100-day supply (Deductible doesn't apply)
Brand-name refills from our mail-order service .....		\$30 for up to a 30-day supply or \$60 for a 31- to 100-day supply (Deductible doesn't apply)
<b>Durable Medical Equipment (DME)</b>		<b>You Pay</b>
Most covered DME for home use in accord with our DME formulary guidelines....		
		20% Coinsurance (Deductible doesn't apply)
<b>Mental Health Services</b>		<b>You Pay</b>
Inpatient psychiatric hospitalization (up to 30 days per calendar year) .....		
		20% Coinsurance after Deductible
Outpatient visits:		
Up to a total of 20 individual and group visits per calendar year .....		\$20 per individual visit (Deductible doesn't apply) \$10 per group visit (Deductible doesn't apply)
Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year .....		\$10 per group visit (Deductible doesn't apply)
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 .....		20% Coinsurance after Deductible
Outpatient individual visits .....		\$20 per visit (Deductible doesn't apply)
Outpatient group visits .....		\$5 per visit (Deductible doesn't apply)
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period) .....		\$100 per admission (Deductible doesn't apply)
<b>Home Health Services</b>		<b>You Pay</b>
Home health care (up to 100 visits per calendar year) .....		No charge (Deductible doesn't apply)
<b>Other</b>		<b>You Pay</b>
Skilled nursing facility care (up to 100 days per benefit period) .....		20% Coinsurance (Deductible doesn't apply)
Covered infertility inpatient care and outpatient surgery .....		50% Coinsurance after Deductible
All other covered Services related to infertility treatment .....		50% Coinsurance (Deductible doesn't apply)
Hospice care .....		No charge (Deductible doesn't apply)

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).