

DISCLOSURE FORM PART ONE — PRINCIPAL BENEFITS FOR  
**KAISER PERMANENTE TRADITIONAL PLAN** (1/1/10—12/31/10)

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 .....  | \$15 per visit |
| Well-child visits (through age 23 months) .....                 | \$5 per visit  |
| Family planning visits .....                                    | \$15 per visit |
| Scheduled prenatal care visits and first postpartum visit ..... | \$5 per visit  |
| Eye exams for refraction .....                                  | \$15 per visit |
| Hearing tests .....   | \$15 per visit |
| Flexible sigmoidoscopies .....                                  | \$15 per visit |
| 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 .....  | \$15 per visit     |
| Group educational programs .....                                 | No charge          |

**Hospitalization Services** You Pay

|   |           |
|---|-----------|
| Room and board, surgery, anesthesia, X-rays, lab tests, and drugs ..... | No charge |
|---|-----------|

**Emergency Health Coverage** You Pay

|                                   |                |
|-----------------------------------|----------------|
| Emergency Department visits ..... | \$75 per visit |
|-----------------------------------|----------------|

Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing)

**Ambulance Services** You Pay

|                          |           |
|--------------------------|-----------|
| Ambulance Services ..... | No charge |
|--------------------------|-----------|

**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                                   |

continued

| <b>Prescription Drug Coverage</b>  |  | <b>You Pay</b>   |
|--|--|--|
| Brand-name items from a Plan Pharmacy .....  |  | \$20 for up to a 30-day supply, \$40 for a 31- to 60-day supply, or \$60 for a 61- to 100-day supply |
| Brand-name refills from our mail-order service.....  |  | \$20 for up to a 30-day supply or \$40 for a 31- to 100-day supply                                   |
| <b>Durable Medical Equipment</b>   |  | <b>You Pay</b>   |
| Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines ..... |  | No charge  |
| <b>Mental Health Services</b>  |  | <b>You Pay</b>   |
| Inpatient psychiatric hospitalization and intensive psychiatric treatment programs .....                               |  | No charge  |
| Outpatient individual and group visits .....   |  | \$15 per individual visit<br>\$7 per group visit   |
| <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  |
| <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).