

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 \$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).