DISCLOSURE FORM PART ONE — PRINCIPAL BENEFITS FOR

KAISER PERMANENTE TRADITIONAL PLAN (1/1/11—12/31/11)

Section 1

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	No charge
Well-child visits (through age 23 months)	No charge
Family planning visits	No charge
Scheduled prenatal care visits and first postpartum visit	No charge
Eye exams for refraction	No charge
Hearing tests	No charge
Flexible sigmoidoscopies	No charge
Colonoscopies	No charge
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	No charge
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	$100 per visit
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing)	
Ambulance Services	**You Pay**
Ambulance Services	No charge

continued

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
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

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs	No charge
Outpatient individual and group visits	$15 per individual visit $7 per group visit

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Outpatient individual visits	$15 per visit
Outpatient group visits	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge

Other	You Pay
Eyewear purchased at Plan Medical Offices or 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).