

DISCLOSURE FORM PART ONE — PRINCIPAL BENEFITS FOR
KAISER PERMANENTE DEDUCTIBLE HMO PLAN (1/1/10—12/31/10) 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 Northern 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 of one Member)	\$3,000 per calendar year
For any one Member in a Family of two or more Members	\$3,000 per calendar year
For an entire Family 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 of one Member)	\$1,000 per calendar year
For any one Member in a Family of two or more Members	\$1,000 per calendar year
For an entire Family of two or more Members	\$2,000 per calendar year

Lifetime Maximum None

Professional Services (Plan Provider office visits) **You Pay**

Routine preventive care:	
Physical exams	\$20 per visit (Deductible doesn't apply)
Well-child 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)
Eye exams for refraction	\$20 per visit (Deductible doesn't apply)
Hearing tests	\$20 per visit (Deductible doesn't apply)
Flexible sigmoidoscopies	\$20 per visit (Deductible doesn't apply)
Primary and specialty care visits	\$20 per visit (Deductible doesn't apply)
Urgent care visits	\$20 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	\$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)
Most 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

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 (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)
Durable Medical Equipment		You Pay
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines		
		20% Coinsurance (Deductible doesn't apply)
Mental Health Services		You Pay
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs		
		20% Coinsurance after Deductible
Outpatient individual and group visits		\$20 per individual visit (Deductible doesn't apply)
		\$10 per group visit (Deductible doesn't apply)
Chemical Dependency Services		You Pay
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)
Home Health Services		You Pay
Home health care (up to 100 visits per calendar year)		
		No charge (Deductible doesn't apply)
Other		You Pay
Skilled nursing facility care (up to 100 days per benefit period)		
		20% Coinsurance (Deductible doesn't apply)
All 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).