

VEBA \$0/\$10 Plan

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	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

Primary and specialty care visits..... No charge

Urgent care visits

Physical, occupational, and speech therapy..... No charge

Outpatient Services You Pay

Outpatient surgery and certain other outpatient procedures

Allergy injection visits

Allergy testing visits.....

Most vaccines (immunizations).....

X-rays and lab tests

Health education:

Individual visits

Group educational programs

Hospitalization Services You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs

Emergency Health Coverage You Pay

Emergency Department visits

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

Prescription Drug Coverage You Pay

Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order service..... \$10 for up to a 100-day supply

Durable Medical Equipment You Pay

Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines

Mental Health Services You Pay

Inpatient psychiatric hospitalization (up to 45 days per calendar year).....

Outpatient visits:

Up to a total of 20 individual and group visits per calendar year

Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year..... No charge per group visit

Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the EOC.

continued

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Outpatient individual visits	No charge
Outpatient group visits	No charge
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period).....	\$100 per admission
Residential rehabilitation (up to 30 days per calendar year)	No charge
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year).....	No charge
Other	You Pay
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).