

Benefit Summary

1799 Sacramento Area Electrical

Principal Benefits for Kaiser Permanente Traditional Plan (1/1/12—12/31/12)

The Services described below are covered only if all of 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 Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

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

Professional Services (Plan Provider office visits)

Most primary and specialty care consultations, exams, and treatment.....	\$20 per visit
Routine physical maintenance exams	No charge
Well-child preventive exams (through age 23 months).....	No charge
Family planning counseling	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam.....	No charge
Eye exams for refraction.....	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	\$20 per visit
Physical, occupational, and speech therapy.....	\$20 per visit

Outpatient Services

Outpatient surgery and certain other outpatient procedures.....	\$500 per procedure
Allergy injections (including allergy serum).....	\$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Health education:

Covered individual health education counseling.....	No charge
Covered health education programs.....	No charge

Hospitalization Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$500 per admission
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Emergency Health Coverage

Emergency Department visits.....	\$100 per visit
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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

Ambulance Services.....	No charge
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Prescription Drug Coverage

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items at 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
Most generic refills through our mail-order service	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply
Most brand-name items at 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
Most brand-name refills through our mail-order service.....	\$30 for up to a 30-day supply or \$60 for a 31- to 100-day supply

Durable Medical Equipment

Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
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Mental Health Services

Inpatient psychiatric hospitalization (up to 45 days per calendar year).....	\$500 per admission
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Outpatient mental health evaluation and treatment:

Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment.....	\$20 per individual visit
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria.....	\$10 per group visit
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria.....	\$10 per visit

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

Chemical Dependency Services

Inpatient detoxification.....	\$500 per admission
Individual outpatient chemical dependency evaluation and treatment.....	\$20 per visit
Group outpatient chemical dependency treatment.....	\$5 per visit

Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period).....

	No charge
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Home Health Services

Home health care (up to 100 visits per calendar year)	No charge
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Other

Skilled nursing facility care (up to 100 days per benefit period).....	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies.....	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).