**Benefit Summary**
**857 Foothill-De Anza Community College District**
**Retirees Contract 2**

**Principal Benefits for Kaiser Permanente Traditional Plan (7/1/11—6/30/12)**

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

| **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** |
|---|---|
| Most primary and specialty care consultations and exams | $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 and exams | $20 per visit |
| Physical, occupational, and speech therapy | $20 per visit |

| **Outpatient Services** | **You Pay** |
|---|---|
| Outpatient surgery and certain other outpatient procedures | $20 per procedure |
| Allergy injections (including allergy serum) | No charge |
| Most immunizations (including vaccines) | No charge |
| Most X-rays and laboratory tests | No charge |
| Health education: | |
| Covered individual health education counseling | No charge |
| Covered health educational programs | No charge |

| **Hospitalization Services** | **You Pay** |
|---|---|
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | No charge |


*continues*

*continued*

| Emergency Health Coverage | You Pay |
|---|---|
| Emergency Department visits | $50 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 |

| Prescription Drug Coverage | You Pay |
|---|---|
| Covered outpatient items in accord with our drug formulary guidelines: | |
| Most generic items from a Plan Pharmacy | $5 for up to a 30-day supply, $10 for a 31- to 60-day supply, or $15 for a 61- to 100-day supply |
| Most generic refills from our mail-order service | $5 for up to a 30-day supply or $10 for a 31- to 100-day supply |
| Most brand-name 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 |
| Most brand-name refills from our mail-order service | $10 for up to a 30-day supply or $20 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 | No charge |
| Outpatient mental health evaluation and treatment | $20 per individual visit<br>$10 per group visit |

| Chemical Dependency Services | You Pay |
|---|---|
| Inpatient detoxification | No charge |
| Individual outpatient chemical dependency counseling and treatment | $20 per visit |
| Group outpatient chemical dependency counseling and treatment | $5 per visit |

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

| Other | You Pay |
|---|---|
| Hearing aid(s) every 36 months | Amount in excess of $500 Allowance per aid |
| 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).