Kaiser Foundation Health Plan, Inc.
Foothill Deanza Community
Benefit Disclosure Form- PT

113436.27.1.S000086596

Disclosure Form Part One — Principal Benefits for Kaiser Permanente Traditional Plan (7/1/07—6/30/08)

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 Service Area, except where specifically noted to the contrary in the *Evidence of Coverage* for authorized referrals, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For any one Member in the same Family Unit	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 per calendar year
Copayments and Coinsurance for most Services count toward this maximum as described in the Evidence of Coverage.	
Deductible or Lifetime Maximum	None
Coordination of Benefits	Included
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and Urgent Care appointments)	$10 per visit
Routine preventive physical exams	$10 per visit
Well-child preventive care visits (0-23 months)	$5 per visit
Family planning visits	$10 per visit
Scheduled prenatal care and first postpartum visit	$5 per visit
Eye exams	$10 per visit
Hearing tests	$10 per visit
Physical, occupational, and speech therapy visits	$10 per visit
Outpatient Services	**You Pay**
Outpatient surgery	$10 per procedure
Allergy injection visits	No charge
Allergy testing visits	$10 per visit
Vaccines (immunizations)	No charge
X-rays and lab tests	No charge
Health education	$10 per individual visit No charge for group visits
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	$50 per visit (does not apply if admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary from Plan Pharmacies:	
Generic items	$5 for up to a 100 day supply
Brand name items	$10 for up to a 100 day supply

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Durable Medical Equipment	**You Pay**
Covered durable medical equipment for home use in accord with our DME formulary	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric care (up to 45 days per calendar year)	No charge
Outpatient visits:	
Up to a total of 20 individual and group therapy visits per calendar year	$10 per individual therapy visit $5 per group therapy visit
Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year	$5 per group therapy visit
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Outpatient individual therapy visits	$10 per visit
Outpatient group therapy visits	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission
Home Health Services	**You Pay**
Home health care (up to 100 two-hour 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, exclusions, or limitations, and it does not list all benefits, Copayments, and Coinsurance. For a complete explanation, please refer to the *Evidence of Coverage*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).