

**Proposed Benefit Summary**

**227805 Beaumont Unified School District(Cert)/High Desert & Inland Trust**

**Standard Plan**

**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 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 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 .....	\$10 per visit
Routine physical maintenance exams .....	\$10 per visit
Well-child preventive exams (through age 23 months) .....	No charge
Family planning counseling.....	\$10 per visit
Scheduled prenatal care exams and first postpartum follow-up consultation and exam .....	No charge
Eye exams for refraction .....	\$10 per visit
Hearing exams .....	\$10 per visit
Urgent care consultations and exams .....	\$10 per visit
Physical, occupational, and speech therapy.....	\$10 per visit

**Outpatient Services** **You Pay**

Outpatient surgery and certain other outpatient procedures .....	\$10 per procedure
Allergy injections (including allergy serum).....	\$5 per visit
Most immunizations (including vaccines) .....	No charge
Most X-rays and laboratory tests .....	No charge
Health education:	
Most individual health education counseling .....	\$10 per visit
Covered health educational programs .....	No charge

**Hospitalization Services** **You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	No charge
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**Emergency Health Coverage** **You Pay**

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** **You Pay**

Ambulance Services .....	\$50 per trip
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**Prescription Drug Coverage** **You Pay**

Covered outpatient items in accord with our drug formulary guidelines:

Most 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
Most generic refills from our mail-order service.....	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply

continued

<b>Prescription Drug Coverage</b>		<b>You Pay</b>
Most brand-name items from a Plan Pharmacy .....		\$25 for up to a 30-day supply, \$50 for a 31- to 60-day supply, or \$75 for a 61- to 100-day supply
Most brand-name refills from our mail-order service .....		\$25 for up to a 30-day supply or \$50 for a 31- to 100-day supply
<b>Durable Medical Equipment</b>		<b>You Pay</b>
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines .....		No charge
<b>Mental Health Services</b>		<b>You Pay</b>
Inpatient psychiatric hospitalization .....		No charge
Outpatient mental health evaluation and treatment .....		\$10 per individual visit \$5 per group visit
<b>Chemical Dependency Services</b>		<b>You Pay</b>
Inpatient detoxification .....		No charge
Individual outpatient chemical dependency counseling and treatment .....		\$10 per visit
Group outpatient chemical dependency counseling and treatment .....		\$5 per visit
<b>Home Health Services</b>		<b>You Pay</b>
Home health care (up to 100 visits per calendar year) .....		No charge
<b>Other</b>		<b>You Pay</b>
Skilled nursing facility care (up to 100 days per benefit period) .....		No charge
All covered Services related to infertility treatment .....		50% Coinsurance
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).