

Proposed Benefit Summary



CSEBA OPT 8

Principal Benefits for Kaiser Permanente Traditional Plan (7/1/15—6/30/16)

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

Accumulation Period

The Accumulation Period for this plan is 1/1/15 through 12/31/15 (calendar year).

Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share during the 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) \$4,000 per calendar year
- For any one Member in a Family of two or more Members \$4,000 per calendar year
- For an entire Family of two or more Members \$8,000 per calendar year

Plan Deductible

None

Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

- Most Primary Care Visits for evaluations and treatment \$20 per visit
- Most Specialty Care Visits for consultations, evaluations, and treatment \$20 per visit
- Routine physical maintenance exams, including well-woman exams No charge
- Well-child preventive exams (through age 23 months) No charge
- Family planning counseling and consultations No charge
- Scheduled prenatal care exams No charge
- Routine eye exams with a Plan Optometrist for Members under age 19 No charge
- Routine eye exams with a Plan Optometrist for Members age 19 and older No charge
- Hearing exams No charge
- Urgent care consultations, evaluations, and treatment \$20 per visit
- Most 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 the vaccine) No charge
- Most X-rays and laboratory tests No charge
- Covered individual health education counseling No charge
- Covered health education programs No charge

Hospitalization Services

You Pay

- Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs No charge

Emergency Health Coverage

You Pay

- Emergency Department visits \$100 per visit

Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

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 at a Plan Pharmacy \$10 for up to a 30-day supply
- Most generic refills through our mail-order service \$20 for up to a 100-day supply

(continues)

Proposed Benefit Summary*(continued)*

Most brand-name items at a Plan Pharmacy	\$20 for up to a 30-day supply
Most brand-name refills through our mail-order service	\$40 for up to a 100-day supply

Durable Medical Equipment (DME)**You Pay**

DME items that are essential health benefits in accord with our DME formulary guidelines	No charge
DME items that are not essential health benefits in accord with our DME formulary guidelines	No charge

Mental Health Services**You Pay**

Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	\$20 per visit
Group outpatient mental health treatment	\$10 per visit

Chemical Dependency Services**You Pay**

Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	\$20 per visit
Group outpatient chemical dependency treatment	\$5 per visit

Home Health Services**You Pay**

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

Skilled nursing facility care (up to 100 days per benefit period)	No charge
Ostomy and urological supplies	No charge
Prosthetic and orthotic devices that are essential health benefits	No charge
Prosthetic and orthotic devices that are not essential health benefits	No charge
All Services related to covered infertility treatment	50% Coinsurance
Hospice care	No charge
Chiropractic Benefit (30 visits per calendar year).....	\$10 per visit

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).