DISCLOSURE FORM PART ONE — PRINCIPAL BENEFITS FOR

KAISER PERMANENTE DEDUCTIBLE HMO PLAN (7/1/10—6/30/11) Section 1

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 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 Care, 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, plus all your Deductible payments, add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$3,000 per calendar year
For any one Member in a Family of two or more Members	$3,000 per calendar year
For an entire Family of two or more Members	$6,000 per calendar year
Deductible for Certain Services as specified below	
You must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:	
For self-only enrollment (a Family of one Member)	$500 per calendar year
For any one Member in a Family of two or more Members	$500 per calendar year
For an entire Family of two or more Members	$1,000 per calendar year
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Routine preventive care:	
Physical exams	$20 per visit (Deductible doesn't apply)
Well-child visits (through age 23 months)	$10 per visit (Deductible doesn't apply)
Scheduled prenatal care visits and first postpartum visit	$10 per visit (Deductible doesn't apply)
Eye exams for refraction	$20 per visit (Deductible doesn't apply)
Hearing tests	$20 per visit (Deductible doesn't apply)
Flexible sigmoidoscopies	$20 per visit (Deductible doesn't apply)
Primary and specialty care visits	$20 per visit (Deductible doesn't apply)
Urgent care visits	$20 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	$20 per visit (Deductible doesn't apply)
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	10% Coinsurance after Deductible
Allergy injection visits	No charge (Deductible doesn't apply)
Allergy testing visits	$20 per visit (Deductible doesn't apply)
Most vaccines (immunizations)	No charge (Deductible doesn't apply)
X-rays and lab tests	$10 per encounter (Deductible doesn't apply)
MRI, CT and PET	$50 per procedure (Deductible doesn't apply)
Health education:	
Individual visits	$20 per visit (Deductible doesn't apply)
Group educational programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	10% Coinsurance after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	10% Coinsurance after Deductible
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip (Deductible doesn't apply)

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continued

Prescription Drug Coverage	You Pay
Most covered outpatient items in accord with our drug formulary guidelines:	
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 (Deductible doesn't apply)
Generic refills from our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Deductible doesn't apply)
Brand-name items from 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 (Deductible doesn't apply)
Brand-name refills from our mail-order service	$30 for up to a 30-day supply or $60 for a 31- to 100-day supply (Deductible doesn't apply)
Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs	10% Coinsurance after Deductible
Outpatient individual and group visits	$20 per individual visit (Deductible doesn't apply) $10 per group visit (Deductible doesn't apply)
Chemical Dependency Services	**You Pay**
Inpatient detoxification	10% Coinsurance after Deductible
Outpatient individual visits	$20 per visit (Deductible doesn't apply)
Outpatient group visits	$5 per visit (Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	10% Coinsurance (Deductible doesn't apply)
Hospice care	No charge (Deductible doesn't apply)

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).