

**Benefit Summary**  
**1857 University of the Pacific**

**Principal Benefits for Kaiser Permanente Traditional Plan (1/1/09—12/31/09)**

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

<b>Annual Out-of-Pocket Maximum for Certain Services</b>	
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 Unit of one Member).....	\$1,500 per calendar year
For any one Member in a Family Unit of two or more Members .....	\$1,500 per calendar year
For an entire Family Unit of two or more Members .....	\$3,000 per calendar year
<b>Deductible or Lifetime Maximum</b>	
	None
<b>Professional Services (Plan Provider office visits)</b>	
<b>You Pay</b>	
Primary and specialty care visits (includes routine and Urgent Care appointments) .....	\$20 per visit
Routine preventive physical exams .....	\$20 per visit
Well-child preventive care visits (through age 23 months) .....	\$5 per visit
Family planning visits .....	\$20 per visit
Scheduled prenatal care visits and first postpartum visit.....	\$5 per visit
Routine preventive refraction exams .....	\$20 per visit
Routine preventive hearing tests .....	\$20 per visit
Physical, occupational, and speech therapy visits .....	\$20 per visit
<b>Outpatient Services</b>	
<b>You Pay</b>	
Outpatient surgery and certain other outpatient procedures .....	\$20 per procedure
Allergy injection visits .....	\$3 per visit
Allergy testing visits.....	\$20 per visit
Vaccines (immunizations) .....	No charge
X-rays and lab tests .....	No charge
Health education:	
Individual visits .....	\$20 per visit
Group educational programs .....	No charge
<b>Hospitalization Services</b>	
<b>You Pay</b>	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs .....	\$100 per admission
<b>Emergency Health Coverage</b>	
<b>You Pay</b>	
Emergency Department visits .....	\$100 per visit (does not apply if admitted directly to the hospital as an inpatient)
<b>Ambulance Services</b>	
<b>You Pay</b>	
Ambulance Services .....	No charge
<b>Prescription Drug Coverage</b>	
<b>You Pay</b>	
Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order service:	
Generic items .....	\$10 for up to a 100-day supply
Brand-name items .....	\$30 for up to a 100-day supply
<b>Durable Medical Equipment (DME)</b>	
<b>You Pay</b>	
Covered DME for home use in accord with our DME formulary guidelines .....	No charge
<b>Mental Health Services</b>	
<b>You Pay</b>	
Inpatient psychiatric hospitalization (up to 30 days per calendar year).....	\$100 per admission
Outpatient visits:	
Up to a total of 20 individual and group visits per calendar year .....	\$20 per individual visit \$10 per group visit

continued

<b>Mental Health Services</b>	<b>You Pay</b>
Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year.....	\$10 per group visit
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the <i>EOC</i> .	
<b>Chemical Dependency Services</b>	<b>You Pay</b>
Inpatient detoxification .....	\$100 per admission
Outpatient individual visits .....	\$20 per visit
Outpatient group 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
<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
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).