
VEBA - \$0/\$5 PLAN

**Principal Benefits for
Kaiser Permanente Traditional Plan (1/1/16—12/31/16)**

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 1/1/16 through 12/31/16 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of 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) \$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

Plan Deductible None

Professional Services (Plan Provider office visits)

You Pay

- Most Primary Care Visits for evaluations and treatment No charge
- Most Specialty Care Visits for consultations, evaluations, and treatment..... No charge
- 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 No charge
- Hearing exams No charge
- Urgent care consultations, evaluations, and treatment..... No charge
- Most physical, occupational, and speech therapy..... No charge

Outpatient Services

You Pay

- Outpatient surgery and certain other outpatient procedures No charge
- 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 \$50 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..... \$5 for up to a 30-day supply
- Most generic refills through our mail-order service \$10 for up to a 100-day supply
- Most brand-name items at a Plan Pharmacy \$10 for up to a 30-day supply
- Most brand-name refills through our mail-order service..... \$20 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

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Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment.....	No charge
Group outpatient mental health treatment.....	No charge
Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment.....	No charge
Group outpatient chemical dependency treatment	No charge
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year).....	No charge
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
Prosthetic and orthotic devices	No charge
Hospice care	No charge

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).