Proposed Benefit Summary
230738 Adelanto School District/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
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit
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
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

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Prescription Drug Coverage	You Pay
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
Durable Medical Equipment	**You Pay**
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Outpatient mental health evaluation and treatment	$10 per individual visit $5 per group visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency counseling and treatment	$10 per visit
Group outpatient chemical dependency counseling and treatment	$5 per visit
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
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).