

Proposed Benefit Summary
230736 Apple Valley Unified 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

continued

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).