KAISER PERMANENTE®

Notice

The Kaiser Permanente *Evidence of Coverage* booklet for the University of California is currently under development. Please check back. This site will be updated once the *Evidence of Coverage* is finalized.

In the interim, please see the attached benefit summary for your Kaiser Permanente Traditional Plan, and your Kaiser Permanente Senior Advantage Plan.

For more information on Kaiser Permanente, please visit our Web site at **members.kp.org**.

Principal Benefits for Kaiser Permanente Traditional Plan (1/1/06—12/31/06)

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 Service Area, except where specifically noted to the contrary in the *Evidence of Coverage* for authorized referrals, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum	
For one Member	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 per calendar year
Deductible or Lifetime Maximum	None
Coordination of Benefits	Included
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and urgent care appointments)	$15 per visit
Routine preventive physical exams	$15 per visit
Well-child preventive care visits (0-23 months)	No charge
Family planning visits	$15 per visit
Scheduled prenatal care and first postpartum visit	No charge
Eye exams	$15 per visit
Hearing tests	$15 per visit
Physical, occupational, and speech therapy visits	$15 per visit
Outpatient Services	**You Pay**
Outpatient surgery	$15 per procedure
Allergy injection visits	$5 per visit
Allergy testing visits	$15 per visit
Immunizations	No charge
X-rays and lab tests	No charge
Health education	$15 per individual visit No charge for group visits
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$250 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit (does not apply if admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary when obtained at Plan Pharmacies:	
Generic items	$10 for a 100-day supply
Brand name items	$20 for a 100-day supply
Durable Medical Equipment	**You Pay**
Covered durable medical equipment for home use in accord with our DME formulary	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric care	$250 per admission
Outpatient visits:	
Individual and group therapy visits	$15 per individual therapy visit $7 per group therapy visit
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$250 per admission
Outpatient individual therapy visits	$15 per visit

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Chemical Dependency Services	You Pay
Outpatient group therapy 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
Home Health Services	**You Pay**
Home health care (up to 100 two-hour visits per calendar year)	No charge
Other	**You Pay**
Hearing aid(s) every 36 months	$1,000 Allowance per aid
Skilled nursing facility care (up to 100 days per calendar year)	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, exclusions, or limitations, and it does not list all benefits, Copayments, and Coinsurance. For a complete explanation, please refer to the *Evidence of Coverage*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Benefit Summary-University of California

Principal Benefits for Kaiser Permanente Senior Advantage with Part D (1/1/06—12/31/06)

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 Service Area, except where specifically noted to the contrary in the *Evidence of Coverage* for authorized referrals, visiting other Regions, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, Out-of-Area dialysis care, and emergency ambulance Services

Senior Advantage is for Members entitled to Medicare, providing the advantages of combined Medicare and Health Plan benefits. Enrollment in this Senior Advantage with Part D plan means that you are automatically enrolled in Medicare Part D.

Annual Out-of-Pocket Maximum	
For one Member	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 per calendar year

Deductible or Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and urgent care appointments)	$15 per visit
Routine preventive physical exams	$15 per visit
Family planning visits	$15 per visit
Scheduled prenatal care and first postpartum visit	No charge
Eye exams and glaucoma screening	$15 per visit
Hearing tests	$15 per visit
Physical, occupational, and speech therapy visits	$15 per visit

Outpatient Services	**You Pay**
Outpatient surgery	$15 per procedure
Allergy injection visits	$3 per visit
Allergy testing visits	$15 per visit
Immunizations	No charge
X-rays, annual mammograms, and lab tests	No charge
Manual manipulation of the spine	$15 per visit
Health education	$15 per individual visit No charge for group visits

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$250 per admission

Emergency Health Coverage	**You Pay**
Emergency Department and Out-of-Area Urgent Care visits	$50 per visit (does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition)

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Ambulance Services	**You Pay**
Ambulance Services	No charge

Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary when obtained at Plan Pharmacies:	
Generic items	$10 for up to a 100-day supply
Brand name items	$20 for up to a 100-day supply

Durable Medical Equipment	**You Pay**
Covered durable medical equipment for home use in accord with our DME formulary	No charge

Mental Health Services	**You Pay**
Inpatient psychiatric care: first 190 days per lifetime as covered by Medicare	$250 per admission
Outpatient visits:	
Individual and group therapy visits	$15 per individual therapy visit $7 per group therapy visit

Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

Chemical Dependency Services	**You Pay**
Inpatient detoxification	$250 per admission
Outpatient individual therapy visits	$15 per visit
Outpatient group therapy 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

Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge

Other	**You Pay**
Eyewear purchased from Plan optical sales offices every 24 months	$150 Allowance
Hearing aid(s) every 36 months	$2,500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, exclusions, or limitations, and it does not list all benefits, Copayments, and Coinsurance. For a complete explanation, please refer to the *Evidence of Coverage*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).