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## Standard Plan Benefit Summary

100103 CITY OF RIVERSIDE  
Standard Plan

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

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

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#### 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

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<b>Deductible or Lifetime Maximum</b>	None
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#### Professional Services (Plan Provider office visits)

#### You Pay

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Most primary and specialty care consultations, exams, and treatment.....	\$15 per visit
Routine physical maintenance exams.....	\$15 per visit
Well-child preventive exams (through age 23 months).....	\$15 per visit
Family planning counseling.....	\$15 per visit
Scheduled prenatal care exams and first postpartum follow-up consultation and exam...	\$15 per visit
Eye exams for refraction .....	\$15 per visit
Hearing exams .....	\$15 per visit
Urgent care consultations, exams, and treatment.....	\$15 per visit
Physical, occupational, and speech therapy .....	\$15 per visit

#### Outpatient Services

#### You Pay

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Outpatient surgery and certain other outpatient procedures .....	\$15 per procedure
Allergy injections (including allergy serum) .....	\$5 per visit
Most immunizations (including the vaccine).....	No charge
Most X-rays and laboratory tests.....	No charge
Health education:	
Most individual health education counseling.....	\$15 per visit
Covered health education programs .....	No charge

#### Hospitalization Services

#### You Pay

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Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	No charge
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#### Emergency Health Coverage

#### You Pay

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Emergency Department visits .....	\$50 per visit
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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

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Ambulance Services .....	\$50 per trip
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#### Prescription Drug Coverage

#### You Pay

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Covered outpatient items in accord with our drug formulary guidelines:

Most generic items at 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 through our mail-order service .....	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply
Most brand-name items at a Plan Pharmacy .....	\$20 for up to a 30-day supply, \$40 for a 31- to 60-day supply, or \$60 for a 61- to 100-day supply
Most brand-name refills through our mail-order service.....	\$20 for up to a 30-day supply or \$40 for a 31- to 100-day supply

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**Standard Plan Benefit Summary***(continued)*

<b>Durable Medical Equipment</b>	<b>You Pay</b>
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines.....	No charge
<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment.....	\$15 per visit
Group outpatient mental health treatment.....	\$7 per visit
<b>Chemical Dependency Services</b>	<b>You Pay</b>
Inpatient detoxification.....	No charge
Individual outpatient chemical dependency evaluation and treatment.....	\$15 per visit
Group outpatient chemical dependency treatment.....	\$5 per visit
<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>
Hearing aid(s) every 36 months.....	Amount in excess of \$1,000 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies.....	No charge
Hospice care.....	No charge

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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).