KAISER PERMANENTE

2008 Summary of Benefits

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street, Rockville, Maryland 20849

VA HMO Essential Plan ($20)

The following is a limited description of benefits offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). Not all services and procedures are covered by your benefits contract. This Summary of Benefits is for comparison purposes only and does not create rights not given through the benefit plan.

PLAN DETAILS		
Copayments	$20 per visit	
Coinsurance (Plan pays / Member pays)	100% / 0% except as otherwise indicated	
Deductible	None	
Maximum Annual Copayment	Individual: $5,000	Other than Individual Coverage: $15,000
Lifetime Maximum	$1,000,000	

BENEFITS	MEMBER PAYS
OUTPATIENT SERVICES	
Well Child Preventive Care	$20 per visit
Office Visit	
Primary Care Office Visit	$20 per visit
Specialty Care Office Visit	$20 per visit
Allergy Injections	Not covered
Routine pre-natal visit (after confirmation of pregnancy) and first post-natal visit	$20 per visit
Diagnostic Tests and Procedures, X-rays & Laboratory Services	$20 per visit
Outpatient Surgery	$20 per visit
HOSPITAL SERVICES	
Inpatient hospital care, including inpatient maternity care, chemical dependency and mental health Services. **Up to age 18**: 21 days of inpatient hospital care and inpatient care beyond 21 days when certified as medically necessary by the Primary Care provider when appropriate utilization review has been conducted and payment authorization has been obtained. **Age 18 and older**: Limited to 21 days per contract year	No charge
CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES	
Outpatient services Limited to 20 visits per contract year	$20 per visit
THERAPY & REHABILITATION SERVICES	
Outpatient physical therapy and occupational therapy Services	Not covered
EMERGENCY SERVICES	
Urgent Care Office Visit	$20 per visit
After hours Urgent Care or Urgent Care Center	$20 per visit
Hospital Emergency Room (waived if admitted as inpatient)	$20 per visit
HOSPITAL ALTERNATIVES	
Skilled Nursing Facility	Not covered
Home Health Care	Not covered
Hospice Care	Not covered
TRANSPLANT SERVICES	
Coverage limited to kidney and cornea only.	No charge
OTHER SERVICES	
Durable Medical Equipment (DME) Purchase or rental of Medicare-approved DME	No charge
Audiology Services	
Out patient speech therapy	Not covered
Hearing aids	Not covered
Prescription Drugs	
Covered prescription drugs (up to a 90-day supply) **NOTE:** You must pay the difference in the cost between the Generic and the Brand name drug when: (a) you request the Brand name drug; (b) there is no Generic drug available; and (c) the prescribing provider does not require the Brand name drug.	**Plan Pharmacy**: $10 per prescription or refill

Vision	
Eyeglass frames and lenses (Limited to one pair of corrective lenses and frame per contract year)	No charge up to a Health Plan maximum payment of $69 for Members up to age 18. All charges above the Plan allowance is the Member's responsibility. Not covered for Members age 18 and older.
ADDITIONAL BENEFITS: **NOTE:** Your employer may purchase, for an additional monthly premium upon contract renewal, enhanced dental benefits. The dental services benefit listed above is automatically included as a base benefit under this medical plan unless your employer purchases an enhanced rider. If your employer elects to purchase an enhanced dental services rider, the benefits provided under that rider will supersede the dental services benefits listed above. Please refer to your Evidence of Coverage if your employer purchased an enhanced dental services rider.	
Dental (Limited to children up to age 18)	
Preventive dental care services, including: ▪ Two examinations ▪ x-rays ▪ two prophylaxes ▪ one topical application of fluoride	No charge for children up to age 18. Not covered for Members age 18 and older.

This Benefit and Service Summary does not fully describe the exclusions and limitations associated with your Kaiser Permanente coverage. For a full list of the general and benefit specific exclusions under your coverage, please refer to your KFHP-MAS Evidence of Coverage (EOC). Your EOC provides you with information on what services and supplies will not be covered, regardless of whether the service is medically necessary.

NOTE: This Summary of Benefits is for comparison purposes only and does not create rights not given through the benefit plan.

Form Numbers: VALG-ALL-SEC1(1/08); VALG-ALL-SEC2(1/08); VASG-ESS1-SEC3(6/02); VASG-ESS-SEC4(6/02); VALG-ALL-SEC5(05/04); VALG-ALL-SEC6(1/04); VALG-ALL-SEC7(1/06); VASG-STES-APDF(6/02); VASG-STES-COP(6/02); and any amendments or riders attached thereto.

Note: These benefits have been filed with the regulatory authority and are pending approval.