MARIN COUNTY EMPLOYEES – Active employees and/or Retirees not eligible for Medicare

Purchaser ID #'s 463 & 603194 (Terminating Customer ID #'s 36344 & 38025) **Note: if not in color, see column heading**

Side-by-Side – High (Terminating), Low, Limited (Terminating) & Silver Traditional HMO Options

If in Kaiser & want to remain in Kaiser: Current Benefits in Green will move to Yellow as default, unless action taken* to move to Silver Option in Pink *requires new enrollment application to be completed and turned in

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

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 Northern 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 Care, 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)	Green HIGH OPTION **You Pay**	Yellow LOW OPTION **You Pay**	Green LIMITED OPTION **You Pay**	Pink SILVER OPTION **You Pay**
Routine preventive care:				
Physical exams	No charge	No charge	No charge	No charge
Well-child visits (through age 23 months)	No charge	No charge	No charge	No charge
Family planning visits	No charge	No charge	No charge	No charge
Scheduled prenatal care visits and first postpartum visit	No charge	No charge	No charge	No charge
Eye refraction exams	No charge	No charge	No charge	No charge
Hearing tests	No charge	No charge	No charge	No charge
Flexible Sigmoidoscopies	No charge	No charge	No charge	No charge
Colonoscopies	No charge	No charge	No charge	No charge
Primary and specialty care visits	No charge	$5 per visit	$15 per visit	$25 per visit
Urgent care visits	No charge	$5 per visit	$15 per visit	$25 per visit
Physical, occupational, and speech therapy	No charge	$5 per visit	$15 per visit	$25 per visit
Outpatient Services	**You Pay**			
Outpatient surgery and certain other outpatient procedures	No charge	$5 per procedure	$15 per procedure	$25 per procedure
Allergy injection visits	No charge	$3 per visit	$3 per visit	$3 per visit
Allergy testing visits	No charge	$5 per visit	$15 per visit	$25 per visit
Most Vaccines (immunizations)	No charge	No charge	No charge	No charge
X-rays and lab tests	No charge	No charge	No charge	No charge
Health education:				
Individual visits	No charge	No charge	No charge	No charge
Group educational programs	No charge	No charge	No charge	No charge

Hospitalization Services	You Pay			
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge	No charge	No charge	No charge
Emergency Health Coverage	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Emergency Department visits	$50 per visit	$50 per visit	$50 per visit	$50 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	$ 50 per trip	$50 per trip	$50 per trip
Prescription Drug Coverage	**You Pay**			
Most covered outpatient items in accord with our drug formulary guidelines:				
Generic items from a Plan Pharmacy	$5 up to a 100 day supply	$5 up to a 100 day supply	$7 up to a 100 day supply	$10 up to a 30 day supply; $20 for a 31-60 day supply, $30 for a 61-100 day supply
Generic refills from our mail-order service	$5 up to a 100 day supply	$5 up to a 100 day supply	$7 up to a 100 day supply	$10 up to a 30 day supply or $20 for a 31-100 day supply
Brand-name items from a Plan Pharmacy	$5 up to a 100 day supply	$5 up to a 100 day supply	$7 up to a 100 day supply	$25 up to a 30-day supply; $50 for 31-60 day supply or $75 for a 61-100 day supply
Brand-name refills from our mail-order service	$5 up to a 100 day supply	$5 up to a 100 day supply	$7 up to a 100 day supply	$25 for up to a 30-day supply or $50 for a 31-100 day supply
Durable Medical Equipment (DME)	**You Pay**			
Most covered DME for home use in accord with our DME formulary guidelines	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
Mental Health Services	**You Pay**			
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs	No charge	No charge	No charge	No charge
Outpatient individual visits	No charge	$5 per visit	$15 per visit	$25 per visit
Outpatient group visits	No charge	$2 per visit	$7 per visit	$12 per visit
Chemical Dependency Services	**You Pay**			
Inpatient detoxification	No charge	No charge	No charge	No charge
Outpatient individual visits	No charge	$5 per visit	$15 per visit	$25 per visit
Outpatient group visits	No charge	$2 per visit	$5 per visit	$5 per visit
Home Health Services	**You Pay**			
Home health care (up to 100 visits per calendar year)	No charge	No charge	No charge	No charge
Chiropractic Services				
Up to 30 visits per year with ASHP Provider – no referral required	$10 per visit	$10 per visit	$10 per visit	$15 per visit
Other	**You Pay**			
Skilled nursing facility care (up to 100 days per benefit period)	No charge	No charge	No charge	No charge
Hospice care	No charge	No charge	No charge	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 an explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).