

Benefit Summary
Mills College Student Health

Principal Benefits for Kaiser Permanente Student Health Plan (8/15/10—8/14/11)

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)	\$3,000 per calendar year
For any one Member in a Family of two or more Members	\$3,000 per calendar year
For an entire Family of two or more Members	\$6,000 per calendar year

Deductible or Lifetime Maximum None

Professional Services (Plan Provider office visits) **You Pay**

Routine preventive care:	
Physical exams	\$20 per visit
Well-child visits (through age 23 months)	\$15 per visit
Family planning visits	\$20 per visit
Scheduled prenatal care visits and first postpartum visit	\$15 per visit
Eye exams for refraction	\$20 per visit
Hearing tests	\$20 per visit
Flexible sigmoidoscopies	\$20 per visit
Primary and specialty care visits	\$20 per visit
Urgent care visits	\$20 per visit
Voluntary termination of pregnancy	\$20 per procedure
Physical, occupational, and speech therapy	\$20 per visit

Outpatient Services **You Pay**

Outpatient surgery and certain other outpatient procedures	\$250 per procedure
Allergy injection visits	\$5 per visit
Allergy testing visits	\$20 per visit
Most vaccines (immunizations)	No charge
X-rays and lab tests	\$10 per encounter
MRI, CT and PET	\$50 per procedure
Health education:	
Individual visits	\$20 per visit
Group educational programs	No charge

Hospitalization Services **You Pay**

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$500 per admission
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Emergency Health Coverage **You Pay**

Emergency Department visits	\$150 per visit
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Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing)

Ambulance Services **You Pay**

Ambulance Services	\$150 per trip
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Prescription Drug Coverage **You Pay**

Most covered outpatient items in accord with our drug formulary guidelines:

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
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
Brand-name items from a Plan Pharmacy		\$30 for up to a 30-day supply, \$60 for a 31- to 60-day supply, or \$90 for a 61- to 100-day supply
Brand-name refills from our mail-order service.....		\$30 for up to a 30-day supply or \$60 for a 31- to 100-day supply
Durable Medical Equipment		You Pay
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines.....		20% Coinsurance
Mental Health Services		You Pay
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs.....		\$500 per admission
Outpatient individual and group visits		\$20 per individual visit \$10 per group visit
Chemical Dependency Services		You Pay
Inpatient detoxification		\$500 per admission
Outpatient individual visits		\$20 per visit
Outpatient group visits		\$5 per visit
Home Health Services		You Pay
Home health care (up to 100 visits per calendar year)		No charge
Other		You Pay
Chiropractic Care		\$15 per visit, up to 20 visits annually
Eyewear purchased from plan optical sales offices every 24 months.....		Amount in excess of \$175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)		No charge
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).