

**NEW HAVEN YOUTH & FAMILY SERVICES,
INC.**

Customer ID # 131397

Traditional HMO Benefits - Low

115854.34.1.S000102706

**Disclosure Form Part One — Principal Benefits for
Kaiser Permanente Traditional Plan (10/1/07—9/30/08)**

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 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 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 after the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

| | |
|--|---------------------------|
| For self-only enrollment (a Family Unit of one Member) | \$1,500 per calendar year |
| For any one Member in a Family Unit of two or more Members | \$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

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|---|----------------|
| Primary and specialty care visits (includes routine and Urgent Care appointments) | \$25 per visit |
| Routine preventive physical exams | \$25 per visit |
| Well-child preventive care visits (0–23 months) | No charge |
| Family planning visits | \$25 per visit |
| Scheduled prenatal care and first postpartum visit | No charge |
| Routine preventive refraction exams | \$25 per visit |
| Routine preventive hearing tests | \$25 per visit |
| Physical, occupational, and speech therapy visits | \$25 per visit |

Outpatient Services

You Pay

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|--|--------------------|
| Outpatient surgery | \$25 per procedure |
| Allergy injection visits | \$5 per visit |
| Allergy testing visits | \$25 per visit |
| Vaccines (immunizations) | No charge |
| X-rays and lab tests | No charge |
| Health education: Individual visits | \$25 per visit |
| Group educational programs | No charge |

Hospitalization Services

You Pay

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|---|---------------------|
| Room and board, surgery, anesthesia, X-rays, lab tests, and drugs | \$250 per admission |
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Emergency Health Coverage

You Pay

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| Emergency Department visits | \$100 per visit (does not apply if admitted directly to the hospital as an inpatient) |
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Ambulance Services

You Pay

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| Ambulance Services | \$50 per trip |
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continued

| 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 program | \$20 for up to a 100-day supply |
| Brand-name items from a Plan Pharmacy | \$25 for up to a 30-day supply, \$50 for a 31 to 60-day supply, or \$75 for a 61 to 100-day supply |
| Brand-name refills from our mail-order program | \$50 for up to 100-day supply |
| Durable Medical Equipment (DME) | You Pay |
| Most covered DME for home use in accord with our DME formulary guidelines | 20% Coinsurance |
| Mental Health Services | You Pay |
| Inpatient psychiatric care (up to 30 days per calendar year) | \$250 per admission |
| Outpatient visits: | |
| Up to a total of 20 individual and group therapy visits per calendar year | \$25 per individual therapy visit \$12 per group therapy visit |
| Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year | \$12 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 EOC. | |
| Chemical Dependency Services | You Pay |
| Inpatient detoxification | \$250 per admission |
| Outpatient individual therapy visits | \$25 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 (up to 100 two-hour visits per calendar year) | No charge |
| Other | You Pay |
| 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).