Benefit Summary

14152 SOLANO-NAPA COUNTIES ELECT. WRKRS H&W TRUST FUND

Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (6/1/14—05/31/15)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary and in accord with Medicare guidelines
- 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, except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*)

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Share 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
Plan Deductible	None
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, evaluations, and treatment	$10 per visit
Annual Wellness visit and the Welcome to Medicare preventive visit	No charge
Routine physical exams	No charge
Eye exams for refraction	$10 per visit
Hearing exams	$10 per visit
Urgent care consultations, exams, and treatment	$10 per visit
Physical, occupational, and speech therapy	$10 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays, annual mammograms, and laboratory tests	No charge
Manual manipulation of the spine	$10 per visit
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
Note: This Cost Share does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition for covered Services or if you are admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	$10 for up to a 100-day supply
Most brand-name items	$15 for up to a 100-day supply
Durable Medical Equipment	**You Pay**
Covered durable medical equipment for home use	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric care	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$10 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge

(continues)

Proposed Benefit Summary *(continued)*

Other	You Pay
Eyewear purchased at Plan Medical Offices or 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
External prosthetic and orthotic devices	No charge
Ostomy and urological supplies	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).