

Proposed Benefit Summary
8161 NECA WEST HEALTH & WELFARE TRUST

Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/10—12/31/10)

The Services described below are covered only if all 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 (your Home Region), 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 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) You Pay

Routine preventive care:

Physical exams.....	\$15 per visit
Family planning visits	\$15 per visit
Scheduled prenatal care visits and first postpartum visit	\$15 per visit
Eye exams for refraction and glaucoma screening	\$15 per visit
Hearing tests.....	\$15 per visit
Primary and specialty care visits.....	\$15 per visit
Urgent care visits.....	\$15 per visit
Physical, occupational, and speech therapy.....	\$15 per visit

Outpatient Services You Pay

Outpatient surgery and certain other outpatient procedures	\$15 per procedure
Allergy injection visits	\$3 per visit
Allergy testing visits.....	\$15 per visit
X-rays, annual mammograms, and lab tests	No charge
Manual manipulation of the spine	\$15 per visit
Health education:	
Individual visits	\$15 per visit
Group educational programs.....	No charge

Hospitalization Services You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs.....	No charge
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Emergency Health Coverage You Pay

Emergency Department visits.....	\$50 per visit
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Note: This Cost Sharing does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition (see "Hospitalization Services" for inpatient Cost Sharing)

Ambulance Services You Pay

Ambulance Services.....	No charge
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Prescription Drug Coverage You Pay

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

Generic items	\$10 for up to a 100-day supply
Brand-name items	\$20 for up to a 100-day supply

Durable Medical Equipment You Pay

Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
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Mental Health Services You Pay

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs.....	No charge
Outpatient individual and group visits	\$15 per individual visit \$7 per group visit

continued

Chemical Dependency Services	You Pay
Inpatient detoxification.....	No charge
Outpatient individual visits.....	\$15 per visit
Outpatient group visits.....	\$5 per visit
Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge
Other	You Pay
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

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).