

Proposed Benefit Summary
Episcopal Diocese of California

Principal Benefits for Kaiser Permanente Senior Advantage (1/1/05—12/31/05)

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 Service Area, except where specifically noted to the contrary for authorized referrals, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services described in the *Evidence of Coverage*

Annual Out-of-Pocket Maximum	
For one Member	\$1,500 per calendar year
For an entire Family Unit	\$3,000 per calendar year
Deductible or Lifetime Maximum	
	None
Professional Services (Plan Provider office visits)	
You Pay	
Primary and specialty care visits (includes routine and urgent care appointments)	\$20 per visit
Routine physical exams	\$20 per visit
Family planning visits	\$20 per visit
Scheduled prenatal care and first postpartum visit	\$15 per visit
Eye exams and glaucoma screening	\$20 per visit
Hearing tests	\$20 per visit
Physical, occupational, and speech therapy visits	\$20 per visit
Outpatient Services	
You Pay	
Outpatient surgery	\$50 per procedure
Allergy injection visits	\$3 per visit
Allergy testing visits	\$20 per visit
Immunizations	No charge
X-rays, annual mammograms, and lab tests	No charge
Manual manipulation of the spine	\$20 per visit
Health education	\$20 per individual visit No charge for group visits
Hospitalization Services	
You Pay	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$500 per admission
Emergency Health Coverage	
You Pay	
Emergency Department and Out-of-Area Urgent Care visits	\$50 per visit (waived if admitted to the hospital as an inpatient within 24 hours for the same condition)
Ambulance Services	
You Pay	
Ambulance Services	\$100 per trip
Prescription Drug Coverage	
You Pay	
Most covered outpatient items in accord with our drug formulary when obtained at Plan Pharmacies (\$1,000 calendar year benefit limit):	
Generic items	\$10 for up to a 100-day supply
Brand name items	\$25 for up to a 100-day supply
Durable Medical Equipment	
You Pay	
Covered durable medical equipment for home use in accord with our DME formulary	20% Coinsurance
Mental Health Services	
You Pay	
Inpatient psychiatric care: first 190 days per lifetime as covered by Medicare. Thereafter, up to 45 days per calendar year	\$500 per admission
Outpatient visits:	
Individual and group therapy visits	\$20 per individual therapy visit \$10 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 <i>Evidence of Coverage</i> .	
Chemical Dependency Services	
You Pay	
Inpatient detoxification	\$500 per admission
Outpatient individual therapy visits	\$20 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 (part-time, intermittent)	No charge
Other	You Pay
Eyewear purchased from Plan optical sales offices every 24 months	\$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge

This is a brief summary of the most frequently asked about benefits and their Copayments and Coinsurance. This chart does not describe benefits and it does not list all benefits, Copayments, and Coinsurance. Please refer to the *Evidence of Coverage* to learn about coverage (including exclusions and limitations) and other benefits, Copayments, and Coinsurance that are not included in this summary. Note: We cover benefits in accord with applicable law (for example, diabetes supplies).