8527 BAY AREA ROOFERS HEALTH & WELFARE TRUST

Principal Benefits for Kaiser Permanente Deductible HMO Plan # 4543 (8/1/14—7/31/15)

The Services described below are covered only if all of 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 Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

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, plus all your payments toward the Plan Deductible, 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

Plan Deductible for Certain Services	
For Services subject to the Plan Deductible, you must pay Charges for Services you receive in a calendar year until you reach one of the following Plan Deductible amounts:	
For self-only enrollment (a Family of one Member)	$1,000 per calendar year
For any one Member in a Family of two or more Members	$1,000 per calendar year
For an entire Family of two or more Members	$2,000 per calendar year
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, evaluations, and treatment	$30 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Eye exams for refraction	No charge (Plan Deductible doesn't apply)
Hearing exams	No charge (Plan Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$30 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$30 per visit (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge (Plan Deductible doesn't apply)
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure (Plan Deductible doesn't apply)
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (Plan Deductible doesn't apply)

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	20% Coinsurance after Plan Deductible

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip (Plan Deductible doesn't apply)

Proposed Benefit Summary *(continued)*

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment	You Pay
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance (Plan Deductible doesn't apply)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$30 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$15 per visit (Plan Deductible doesn't apply)

Chemical Dependency Services	You Pay
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	$30 per visit (Plan Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Plan Deductible doesn't apply)

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge (Plan Deductible doesn't apply)

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance (Plan Deductible doesn't apply)
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge (Plan Deductible doesn't apply)
All Services related to covered infertility treatment	50% Coinsurance (Plan Deductible doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)

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).