100103 CITY OF RIVERSIDE
PREFERRED PLAN &
MIDWAY PLAN

Disclosure Form Part One — 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 Southern 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	$10 per visit
Family planning visits	$10 per visit
Scheduled prenatal care visits and first postpartum visit	$10 per visit
Eye exams for refraction and glaucoma screening	$10 per visit
Hearing tests	$10 per visit
Primary and specialty care visits	$10 per visit
Urgent care visits	$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 injection visits	$3 per visit
Allergy testing visits	$10 per visit
X-rays, annual mammograms, and lab tests	No charge
Manual manipulation of the spine	$10 per visit
Health education:	
Individual visits	$10 per visit
Group educational programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$200 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
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	$50 per trip

continued

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	$35 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	20 percent Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$200 per admission
Outpatient individual and group visits	$10 per individual visit $5 per group visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$200 per admission
Outpatient individual visits	$10 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 $150 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).