Summary of Benefits for
Kaiser Permanente Senior Advantage (HMO) with Part D (7/1/12—6/30/13)

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 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)

<table>
<thead>
<tr>
<th>You Pay</th>
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<tbody>
<tr>
<td>Most primary and specialty care consultations, exams, and treatment ......................................................... $15 per visit</td>
</tr>
<tr>
<td>Annual Wellness Visit and the Welcome to Medicare Exam ....... No charge</td>
</tr>
<tr>
<td>Eye exams for refraction ........................................................................................................ $15 per visit</td>
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<tr>
<td>Hearing exams ......................................................................................................................... $15 per visit</td>
</tr>
<tr>
<td>Urgent care consultations, exams, and treatment................................. $15 per visit</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy ................................ $15 per visit</td>
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</table>

### Outpatient Services

<table>
<thead>
<tr>
<th>You Pay</th>
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<tbody>
<tr>
<td>Outpatient surgery and certain other outpatient procedures ........ $15 per procedure</td>
</tr>
<tr>
<td>Allergy injections (including allergy serum) .............................. $3 per visit</td>
</tr>
<tr>
<td>Most immunizations (including the vaccine) ................................. No charge</td>
</tr>
<tr>
<td>Most X-rays, annual mammograms, and laboratory tests ............... No charge</td>
</tr>
<tr>
<td>Manual manipulation of the spine ............................................... $15 per visit</td>
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</tbody>
</table>
| Health education:  
  Most individual health education counseling ......................... $15 per visit |
  Covered health education programs........................................ No charge |

### Hospitalization Services

<table>
<thead>
<tr>
<th>You Pay</th>
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</thead>
<tbody>
<tr>
<td>Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .................................................. No charge</td>
</tr>
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</table>

### Emergency Health Coverage

<table>
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<tr>
<th>You Pay</th>
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<tbody>
<tr>
<td>Emergency Department visits ................................................... $35 per visit</td>
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</tbody>
</table>

Note: This Cost Sharing 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 Sharing).

### Ambulance Services

<table>
<thead>
<tr>
<th>You Pay</th>
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<tbody>
<tr>
<td>Ambulance Services .............................................................. No charge</td>
</tr>
</tbody>
</table>
### Prescription Drug Coverage
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**
  - $20 for up to a 100-day supply

### Durable Medical Equipment
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines:

- **No charge**

### Mental Health Services

- **Inpatient psychiatric hospitalization**
  - **No charge**
- **Individual outpatient mental health evaluation and treatment**
  - $15 per visit
- **Group outpatient mental health treatment**
  - $7 per visit

### Chemical Dependency Services

- **Inpatient detoxification**
  - **No charge**
- **Individual outpatient chemical dependency evaluation and treatment**
  - $15 per visit
- **Group outpatient chemical dependency treatment**
  - $5 per visit

### Home Health Services

- **Home health care (part-time, intermittent)**
  - **No charge**

### Other

- **Eyewear purchased at Plan Medical Offices or plan optical sales offices every 24 months**
  - Amount in excess of $175 Allowance
- **Hearing aid(s) every 36 months**
  - Amount in excess of $1,500 Allowance per aid
- **Skilled nursing facility care (up to 100 days per benefit period)**
  - **No charge**
- **External prosthetic devices, orthotic devices, and ostomy and urological supplies**
  - **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 a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).