Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (7/1/10—6/30/11)

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	No charge
Family planning visits	$20 per visit
Scheduled prenatal care visits and first postpartum visit	No charge
Eye exams for refraction and glaucoma screening	$20 per visit
Hearing tests	$20 per visit
Primary and specialty care visits	$20 per visit
Urgent care visits	$20 per visit
Physical, occupational, and speech therapy	$20 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Allergy injection visits	No charge
Allergy testing visits	$20 per visit
Most vaccines (immunizations)	No charge
X-rays, annual mammograms, and lab tests	No charge
Manual manipulation of the spine	$20 per visit
Health education:	
Individual visits	$20 per visit
Group educational programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge
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	No charge
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy	$5 for up to a 30-day supply, $10 for a 31- to 60-day supply, or $15 for a 61- to 100-day supply
Generic refills from our mail-order service	$5 for up to a 30-day supply or $10 for a 31- to 100-day supply
Brand-name items from a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply
Brand-name refills from our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply

continues

continued

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs	No charge
Outpatient individual and group visits	$20 per individual visit $10 per group visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Outpatient individual visits	$20 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
Hearing aid(s) every 36 months	Amount in excess of $500 Allowance per aid
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).