

Benefit Summary

229065/ 602567 LLNL- Group KPSA HRA Plan- \$20 office Visit

Principal Benefits for Kaiser Permanente Senior Advantage 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
- 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)*

Senior Advantage is for Members entitled to Medicare, providing the advantages of combined Medicare and Health Plan benefits. Enrollment in this Senior Advantage with Part D plan means that you are automatically enrolled in Medicare Part D.

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	
	None
Lifetime Maximum	
All other Services	None
Professional Services (Plan Provider office visits)	
You Pay	
Routine preventive care:	
Physical exams	\$20 per visit
Family planning visits	\$20 per visit
Scheduled prenatal care visits and first postpartum visit	No charge
Eye refraction exams 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	\$3 per visit
Allergy testing visits	\$20 per visit
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	\$250 per admission
Emergency Health Coverage	
You Pay	
Emergency Department and Out-of-Area Urgent Care visits	\$50 per visit (does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition)
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	\$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
Generic refills from our mail-order service	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply

continued

Prescription Drug Coverage		You Pay
Brand-name items from a Plan Pharmacy		\$25 for up to a 30-day supply, \$50 for a 31- to 60-day supply, or \$75 for a 61- to 100-day supply
Brand-name refills from our mail-order service.....		\$25 for up to a 30-day supply or \$50 for a 31- to 100-day supply
Durable Medical Equipment (DME)		You Pay
Covered DME for home use in accord with our DME formulary and Medicare guidelines.....		No charge
Mental Health Services		You Pay
Inpatient psychiatric hospitalization		\$250 per admission
Outpatient individual and group visits		\$15 per individual visit \$7 per group visit
Chemical Dependency Services		You Pay
Inpatient detoxification		\$250 per admission
Outpatient individual visits		\$20 per visit
Outpatient group 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.....		Amount in excess of \$150 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
Prosthetic and orthotic devices or ostomy and urological supplies in accord with Medicare guidelines		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).