All plans offered and underwritten by Kaiser Foundation Health Plan
of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Kaiser Permanente Senior Advantage (HMO)
Summary of medical benefits with Part D

Lewis & Clark College 1336
January 1, 2013 through December 31, 2013

Out-of-Pocket Maximum (Not all Services apply to the maximum.)	
For one Member	$1,000 per Calendar Year
Preventive Care Services	**You pay**
"Welcome to Medicare" preventive visit	$0
Annual routine physical exam	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	**You pay**
Primary care visit	$10
Specialty care visit	$20
Urgent care visit	$15
Emergency department visit	$50 (Waived if admitted)
Outpatient surgery visit	$50
Chemotherapy/radiation therapy visit	$20
Laboratory, X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$50
Routine eye exam	$10
Injection visit provided in nurse treatment area	$10
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance
Diabetes self-monitoring, training and supplies	$0
Physical, speech, and occupational therapies (no limit)	$20
Inpatient Hospital Services	$100 per day up to $500 per admission
Ambulance Services (per one-way trip)	$75
Outpatient Prescription Drugs, Supplies, and Supplements	
Medicare – Part B	$0
Medicare – Part D	50% up to $25 limit per prescription for 30-day supply; up to $50 limit per prescription for 90-day supply of mail order maintenance drugs. After you have paid $4,750 in true out-of-pocket cost for Part D covered drugs in a calendar year, you will pay the lesser of your copayment or $3 generic and $7 brand per prescription. The better of Part D and standard formulary applies. We cover nonformulary drugs only when you meet exception criteria.

Skilled Nursing Facility Services (up to 100 days per Medicare Benefit Period)	$0
Travel Benefit	20%. The annual benefit maximum is $1,250. Kaiser Permanente pays 80% up to $1,000 per year. You pay 100% thereafter. (In the U.S. only.)
Health Fitness Program	$0 for basic fitness facility membership at affiliated facilities.
Optional Benefits	
Alternative Care (self-referred)	Not covered
Hearing Aids	Not covered
Vision Hardware and Optical Services	Balance after $150 allowance every 24 months
Chemical Dependency Services	
Outpatient Services/Day treatment	$10 (per day for day treatment)
Inpatient Hospital	$100 per day up to $500 per admission
Residential (partial hospitalization)	Lesser of half of inpatient hospital or $110
Mental Health Services	
Outpatient Services/Day treatment	$10 (per day for day treatment)
Inpatient Hospital	$100 per day up to $500 per admission
Residential (partial hospitalization)	Lesser of half of inpatient hospital or $110

Exclusions and Limitations

The following summary applies to all Services that would otherwise be covered under this *Summary of medical benefits with Part D (Summary)* and are in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in this *Summary*.

Acupuncture. Limited to when the Alternative Therapies rider has been purchased.; **Certain exams and Services**; **Chiropractic Services** are generally not covered under the plan, with the exception of manual manipulation of the spine and are limited according to Medicare guidelines, or when the Alternative Therapies or Alternative Therapies - Chiropractic Services rider has been purchased.; **Cosmetic Services**; **Custodial Services**; **Dental Services.** Except when Medically Necessary for Members who have a medical condition that would place undue risk if performed in a dental office. The procedure must be approved.; **Designated blood donations**; **Detained or confined members**; **Educational and clinical programs for weight control; Employer responsibility**; **Experimental or investigational Services unless covered by the Original Medicare Plan.** However, certain services may be covered under a Medicare approved clinical research study. See the Evidence of Coverage for more information.; **Eye surgery.** Except cataract surgery covered by Medicare.; **Family Services.** Services provided by a member of your immediate family.; **Genetic testing**; **Government agency responsibility.** Not including Medicaid.; **Hearing aids.** Unless the Hearing Aid rider has been purchased. Does apply to cochlear implants and osseointegrated external hearing devices covered by Medicare.; **Homemaker Services; Hypnotherapy**; **Intermediate Services**; **Low-vision aids. Massage therapy Services.** Limited to when: (a) a plan physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Therapies rider has been purchased.; **Naturopathy Services.** Unless Alternative Therapies rider has been purchased.; **Non-Medically Necessary Services**; **Nonconventional intraocular lenses (IOLs) following cataract surgery; Nonreusable take home medical supplies.** Unless supplies meet the DME definition and criteria.; **Outpatient Prescription Drugs.** Unless the Outpatient Prescription Drug rider has been purchased.; **Professional Services for fitting and follow-up care for contact**

lenses; **Routine foot care**; **Services not approved by the federal Food and Drug Administration; Services related to a non-covered Service.** Unless the services would be covered to treat complications arising after the non-covered Service.; **Services that are not health care Services, supplies, or items; Sexual reassignment surgery**; **Supportive care and other Services**; **Surgical treatment of morbid obesity *unless* medically necessary and covered under the Original Medicare plan; Travel and lodging.** Limited to: (a) Medically Necessary "Ambulance Services" in this *Summary*, and (b) certain expenses that we preauthorize under transplants.; **Vision hardware and optical Services.** Unless the Vision Hardware and Optical Services rider has been purchased. Except routine eye exams and eyewear following cataract surgery covered by Medicare.; **Vision therapy and orthoptics or eye exercises**.

Questions? Call Membership Services (Daily, 8 am-8 pm) or visit **kp.org**
All areas.. 1-877-221-8221. TTY..1-800-735-2900.

An HMO with a Medicare contract.

The benefit information provided herein is a brief summary, but not a comprehensive description of available benefits. Additional information about benefits is available to assist you in making a decision about your coverage. This is an advertisement; for more information contact the plan. This *Summary*, customized for your group by Kaiser Foundation Health Plan of the Northwest, is not a contract and does not replace nor take precedence over your Evidence of Coverage (EOC).