

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/20—12/31/20)

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:

For any one Member \$1,500 per calendar year

Plan Deductible

None

Professional Services (Plan Provider office visits)

You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits	\$10 per visit
Most Physician Specialist Visits	\$10 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	\$10 per visit
Urgent care consultations, evaluations, and treatment	\$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 injections (including allergy serum)	\$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests.....	No charge
Manual manipulation of the spine	\$10 per visit

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$200 per admission
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Emergency Health Coverage

You Pay

Emergency Department visits	\$50 per visit
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Ambulance Services

You Pay

Ambulance Services	\$50 per trip
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Prescription Drug Coverage

You Pay

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	\$35 for up to a 100-day supply

Durable Medical Equipment (DME)

You Pay

Covered durable medical equipment for home use	20 percent Coinsurance
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Mental Health Services

You Pay

Inpatient psychiatric hospitalization.....	\$200 per admission
Individual outpatient mental health evaluation and treatment	\$10 per visit
Group outpatient mental health treatment.....	\$5 per visit

continued

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$200 per admission
Individual outpatient substance use disorder evaluation and treatment.....	\$10 per visit
Group outpatient substance use disorder treatment	\$5 per visit
Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge
Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices.....	20 percent Coinsurance
Ostomy and urological supplies	20 percent Coinsurance

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For more information, please refer to the *Summary of Benefits* booklet enclosed.