Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (10/1/18—9/30/19)

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 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
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$25 per visit
Most Physician Specialist Visits	$25 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	$25 per visit
Urgent care consultations, evaluations, and treatment	$25 per visit
Physical, occupational, and speech therapy	$25 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$25 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$20 per visit
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at 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
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply

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Prescription Drug Coverage	You Pay
Most brand-name items at 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
Most brand-name refills through 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 durable medical equipment for home use	20 percent Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$500 per admission
Individual outpatient mental health evaluation and treatment	$25 per visit
Group outpatient mental health treatment	$12 per visit

Chemical Dependency Services	You Pay
Inpatient detoxification	$500 per admission
Individual outpatient chemical dependency evaluation and treatment	$25 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Hearing aid(s) every 36 months	Amount in excess of $500 Allowance per aid
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.