

## Benefit Summary

100103 CITY OF RIVERSIDE – Senior Advantage HMO 15 (no Chiropractor)

### Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/15—12/31/15)

The Services described below are covered only if all of 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 Southern California Region Service Area, except where specifically noted to the contrary in the *Evidence of Coverage (EOC)*

#### Accumulation Period

The Accumulation Period for this plan is 1/1/15 through 12/31/15 (calendar year).

#### Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share during 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

#### Lifetime Maximum

None

#### Professional Services (Plan Provider office visits)

#### You Pay

Most Primary Care Visits for evaluations and treatment .....	\$15 per visit
Most Specialty Care Visits for consultations, evaluations, and treatment .....	\$15 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 .....	\$15 per visit
Hearing exams .....	\$15 per visit
Urgent care consultations, exams, and treatment .....	\$15 per visit
Physical, occupational, and speech therapy .....	\$15 per visit

#### Outpatient Services

#### You Pay

Outpatient surgery and certain other outpatient procedures .....	\$150 per procedure
Allergy injections (including allergy serum) .....	\$3 per visit
Most immunizations (including the vaccine) .....	No charge
Most X-rays, annual mammograms, and laboratory tests .....	No charge
Manual manipulation of the spine .....	\$15 per visit

#### Hospitalization Services

#### You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	\$500 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 .....	\$125 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 care .....	\$500 per admission
Individual outpatient mental health evaluation and treatment .....	\$15 per visit
Group outpatient mental health treatment .....	\$7 per visit

#### Chemical Dependency Services

#### You Pay

Inpatient detoxification .....	\$500 per admission
Individual outpatient chemical dependency evaluation and treatment .....	\$15 per visit
Group outpatient chemical dependency treatment .....	\$5 per visit

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**Proposed Benefit Summary***(continued)*

<b>Home Health Services</b>	<b>You Pay</b>
Home health care (part-time, intermittent) .....	No charge
<b>Other</b>	<b>You Pay</b>
Eyewear purchased at Plan Medical Offices or Plan Optical Sales Offices every 24 months .....	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period) .....	No charge (up to 20 days) \$75 per day (days 21–100)
External prosthetic and orthotic devices .....	20 percent Coinsurance
Ostomy and urological supplies .....	20 percent Coinsurance

This is a summary of the most frequently asked-about benefits. 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 a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).