

**Summary of Benefits Chart for
 Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/17—12/31/17)**

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 \$15 per visit
- \$15 per visit
- Most Physician Specialist Visits \$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
- Urgent care consultations, evaluations, 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

Emergency Health Coverage You Pay

- Emergency Department visits \$50 per visit

Ambulance Services You Pay

- Ambulance Services \$125 per trip

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

Mental Health Services You Pay

- Inpatient psychiatric hospitalization \$500 per admission

continued

Mental Health Services	You Pay
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
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 (up to 20 days) \$75 per day (days 21–100)
External prosthetic and orthotic devices	20 percent Coinsurance
<u>Ostomy and urological supplies</u>	<u>20 percent Coinsurance</u>

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 more information, please refer to the *Summary of Benefits* booklet enclosed. Please note that we provide all benefits required by law (for example, diabetes testing supplies).