## Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/19—12/31/19)

### 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 the following amount:

- For any one Member ................................................................. $1,500 per calendar year

### Professional Services (Plan Provider office visits)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Primary Care Visits and most Non-Physician Specialist Visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Most Physician Specialist Visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Annual Wellness visit and the &quot;Welcome to Medicare&quot; preventive visit</td>
<td>No charge</td>
</tr>
<tr>
<td>Routine physical exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Routine eye exams with a Plan Optometrist</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Urgent care consultations, evaluations, and treatment</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>

### Outpatient Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery and certain other outpatient procedures</td>
<td>$50 per procedure</td>
</tr>
<tr>
<td>Allergy injections (including allergy serum)</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Most immunizations (including the vaccine)</td>
<td>No charge</td>
</tr>
<tr>
<td>Most X-rays and laboratory tests</td>
<td>No charge</td>
</tr>
<tr>
<td>Manual manipulation of the spine</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>

### Hospitalization Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs</td>
<td>$500 per admission</td>
</tr>
</tbody>
</table>

### Emergency Health Coverage

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department visits</td>
<td>$50 per visit</td>
</tr>
</tbody>
</table>

### Ambulance Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>$100 per trip</td>
</tr>
</tbody>
</table>

### Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered outpatient items in accord with our drug formulary guidelines:</td>
<td>$10 for up to a 100-day supply</td>
</tr>
</tbody>
</table>

- 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)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered durable medical equipment for home use</td>
<td>20 percent Coinsurance</td>
</tr>
</tbody>
</table>

### Mental Health Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient psychiatric hospitalization</td>
<td>$500 per admission</td>
</tr>
<tr>
<td>Individual outpatient mental health evaluation and treatment</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Group outpatient mental health treatment</td>
<td>$7 per visit</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment</td>
<td>You Pay</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Inpatient detoxification</td>
<td>$500 per admission</td>
</tr>
<tr>
<td>Individual outpatient treatment</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Group outpatient treatment</td>
<td>$5 per visit</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Health Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (part-time, intermittent)</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglasses or contact lenses</td>
<td>Amount in excess of $150 Allowance</td>
</tr>
<tr>
<td>Skilled nursing facility care</td>
<td>No charge</td>
</tr>
<tr>
<td>External prosthetic and orthotic</td>
<td>20 percent Coinsurance</td>
</tr>
<tr>
<td>Ostomy and urological supplies</td>
<td>20 percent Coinsurance</td>
</tr>
</tbody>
</table>

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.