

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

<b>Plan Out-of-Pocket Maximum</b>	
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	
<b>Plan Deductible</b>	None
<b>Professional Services (Plan Provider office visits)</b>	<b>You Pay</b>
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
<b>Outpatient Services</b>	<b>You Pay</b>
Outpatient surgery and certain other outpatient procedures .....	\$10 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 .....	\$10 per visit
<b>Hospitalization Services</b>	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	No charge
<b>Emergency Health Coverage</b>	<b>You Pay</b>
Emergency Department visits .....	\$50 per visit
<b>Ambulance Services</b>	<b>You Pay</b>
Ambulance Services .....	No charge
<b>Prescription Drug Coverage</b>	<b>You Pay</b>
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 .....	\$20 for up to a 100-day supply
Most specialty drugs .....	20 percent Coinsurance (not to exceed \$100) for up to a 100-day supply
<b>Durable Medical Equipment (DME)</b>	<b>You Pay</b>
Covered durable medical equipment for home use .....	No charge
<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization.....	No charge

continued

<b>Mental Health Services</b>	<b>You Pay</b>
Individual outpatient mental health evaluation and treatment .....	\$10 per visit
Group outpatient mental health treatment.....	\$5 per visit
<b>Substance Use Disorder Treatment</b>	<b>You Pay</b>
Inpatient detoxification .....	No charge
Individual outpatient substance use disorder evaluation and treatment.....	\$10 per visit
Group outpatient substance use disorder treatment .....	\$5 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (part-time, intermittent) .....	No charge
<b>Other</b>	<b>You Pay</b>
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.....	No charge
Ostomy and urological supplies .....	No charge

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.