

**Summary of Benefits Chart for
Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/18—12/31/18)**

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	
Plan Deductible	None
Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	No charge
Most Physician Specialist Visits	No charge
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	No charge
Physical, occupational, and speech therapy	No charge
Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	No charge
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	No charge
Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	You Pay
Emergency Department visits	\$50 per visit
Ambulance Services	You Pay
Ambulance Services	No charge
Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	\$5 for up to a 30-day supply, \$10 for a 31- to 60-day supply, or \$15 for a 61- to 100-day supply
Most generic refills through our mail-order service	\$5 for up to a 30-day supply or \$10 for a 31- to 100-day supply

continued

Prescription Drug Coverage	You Pay
Most brand-name 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 brand-name refills through our mail-order service	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply
Durable Medical Equipment (DME)	You Pay
Covered durable medical equipment for home use	No charge
Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment	No charge
Group outpatient mental health treatment.....	No charge
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment.....	No charge
Group outpatient substance use disorder treatment	No charge
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
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.