**233977 CSAC EIA - CSURMA SOUTH**

# Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/20—12/31/20)

| 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 | $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 |
| **Outpatient Services** | **You Pay** |
| Outpatient surgery and certain other outpatient procedures | $10 per procedure |
| Allergy injections (including allergy serum) | $3 per visit |
| Most immunizations (including the vaccine) | No charge |
| Most X-rays and laboratory tests | No charge |
| Manual manipulation of the spine | $10 per visit |
| **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 | $20 for up to a 30-day supply, $40 for a 31- to 60-day supply, or $60 for a 61- to 100-day supply |
| Most brand-name refills through our mail-order service | $20 for up to a 30-day supply or $40 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 | $10 per visit |
| Group outpatient mental health treatment | $5 per visit |
| **Substance Use Disorder Treatment** | **You Pay** |
| Inpatient detoxification | No charge |
| Individual outpatient substance use disorder evaluation and treatment | $10 per visit |
| Group outpatient substance use disorder 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 $175 Allowance |
| Hearing aid(s) every 36 months | Amount in excess of $1,000 Allowance per aid |
| 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.