**888 HEALTH SERVICE SYSTEM SAN FRANCISCO**

## Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/17—12/31/17)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary and in accord with Medicare guidelines
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area, except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*)

| **Accumulation Period** | |
|---|---|
| The Accumulation Period for this plan is 1/1/17 through 12/31/17 (calendar year). | |
| **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 | $20 per visit |
| Most Physician Specialist Visits | $20 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 | No charge |
| Hearing exams | No charge |
| Urgent care consultations, evaluations, and treatment | $20 per visit |
| Physical, occupational, and speech therapy | $20 per visit |
| **Outpatient Services** | **You Pay** |
| Outpatient surgery and certain other outpatient procedures | $35 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 | $20 per visit |
| **Hospitalization Services** | **You Pay** |
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | $100 per admission |
| **Emergency Health Coverage** | **You Pay** |
| Emergency Department visits | $50 per visit |
| **Ambulance Services** | **You Pay** |
| Ambulance Services | No charge |

*(continues)*

| 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 |
| Most brand-name items at a Plan Pharmacy | $15 for up to a 30-day supply, $30 for a 31- to 60-day supply, or $45 for a 61- to 100-day supply |
| Most brand-name refills through our mail-order service | $15 for up to a 30-day supply or $30 for a 31- to 100-day supply |
| Most specialty drugs | 20% Coinsurance (not to exceed $100) for up to a 30-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 | $100 per admission |
| Individual outpatient mental health evaluation and treatment | $20 per visit |
| Group outpatient mental health treatment | $10 per visit |
| **Chemical Dependency Services** | **You Pay** |
| Inpatient detoxification | $100 per admission |
| Individual outpatient chemical dependency evaluation and treatment | $20 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** |
| Hearing aid(s) every 36 months | Amount in excess of $2,500 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 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 a complete explanation, please refer to the *EOC*. Please note that we provide all benefits reqpuired by law (for example, diabetes testing supplies).