

8972 SAN MATEO ELECTRICAL
WORKERS HEALTH CARE

**Summary of Benefits Chart for
Kaiser Permanente Senior Advantage (HMO) with Part D (6/1/19—5/31/20)**

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
.....	\$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	\$100 per admission
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Emergency Health Coverage You Pay

Emergency Department visits	\$35 per visit
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Ambulance Services You Pay

Ambulance Services	\$50 per trip
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Prescription Drug Coverage You Pay

Most covered outpatient items in accord with our drug formulary guidelines.....	\$10 for up to a 100-day supply
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Durable Medical Equipment (DME) You Pay

Covered durable medical equipment for home use	No charge
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Mental Health Services You Pay

Inpatient psychiatric hospitalization.....	\$100 per admission
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	\$100 per admission
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continued

Substance Use Disorder Treatment		You Pay
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
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.