Benefit Summary

KAISER PERMANENTE

Customer Name: **San Francisco Health Service System**
Customer ID: **888 Northern California & 231003 Southern California**

Principal Benefits for
Kaiser Permanente Senior Advantage Plan (1/1/20—12/31/20)

Accumulation Period

The Accumulation Period for this plan is 1/1/20 through 12/31/20 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	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
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
Most 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 injection visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
MRI, most CT, and PET scans	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

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

Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

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
Most generic refills through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$15 for up to a 30-day supply
Most brand-name refills through our mail-order service	$30 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	20% Coinsurance (not to exceed $100) for up to a 100-day supply

(continues)

Durable Medical Equipment (DME)	**You Pay**
DME items as described in the EOC	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

Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$100 per admission
Individual outpatient substance use disorder evaluation and treatment	$20 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**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the EOC	No charge
Hospice care	No charge
Hearing aids	$2,500 allowance, for each ear, every 36 months
Chiropractic care and Acupuncture Care	$15 per visit (up to 30 combined visits per year)

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 required by law (for example, diabetes testing supplies).