
DEPARTMENT OF WATER & POWER - RETIREES

**Principal Benefits for
Kaiser Permanente Senior Advantage (HMO) with Part D (7/1/17—6/30/18)**

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 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 | \$5 per visit |
| Most Physician Specialist Visits | \$5 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 | \$5 per visit |
| Urgent care consultations, evaluations, and treatment | \$5 per visit |
| Physical, occupational, and speech therapy | \$5 per visit |

Outpatient Services You Pay

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|--|-------------------|
| Outpatient surgery and certain other outpatient procedures | \$5 per procedure |
| Allergy injections (including allergy serum) | No charge |
| Most immunizations (including the vaccine) | No charge |
| Most X-rays, annual mammograms, and laboratory tests | No charge |
| Manual manipulation of the spine | \$5 per visit |

Hospitalization Services You Pay

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|--|-----------|
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | No charge |
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Emergency Health Coverage You Pay

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|-----------------------------------|---------------|
| Emergency Department visits | \$5 per visit |
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Ambulance Services You Pay

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|--------------------------|-----------|
| Ambulance Services | No charge |
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Prescription Drug Coverage You Pay

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| Most covered outpatient items in accord with our drug formulary guidelines | \$5 for up to a 100-day supply |
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Durable Medical Equipment (DME) You Pay

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

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| Inpatient psychiatric hospitalization | No charge |
| Individual outpatient mental health evaluation and treatment | \$5 per visit |
| Group outpatient mental health treatment | \$2 per visit |

| Chemical Dependency Services | You Pay |
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| Inpatient detoxification | No charge |
| Individual outpatient chemical dependency evaluation and treatment..... | \$5 per visit |
| Group outpatient chemical dependency treatment | \$2 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 \$150 Allowance |
| Hearing aid(s) every 36 months | Amount in excess of \$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 more information, please refer to the *Summary of Benefits* booklet enclosed. Please note that we provide all benefits required by law (for example, diabetes testing supplies).