Medicare Eligible / Post-65 Only	Kaiser Permanente Senior Advantage HMO - Colorado
Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.	
Plan Changes are in Orange	**2027 In-Network**
General Information	
Lifetime Maximum Benefit	None
Annual Maximum Benefit	None
Coinsurance Percentage	None
Precertification Requirements	N/A
Precertification Penalty	N/A
Health Savings Account (HSA)	N/A
Health Reimbursement Account (HRA)	N/A
R & C	None
Deductibles	
Individual Annual Deductible	None
Family Annual Deductible	None
Applies to Out-of-Pocket Maximum	N/A
Prescription benefits are covered under medical deductible	N/A
Out-of-Pocket Mx per Plan Year	
Individual Out-of-Pocket Maximum Per Year	$3,000.00
Family Out-of-Pocket Maximum Per Year	Only individual OOPM applies
Outpatient Services	
Primary Care Physician Visits	$20 per visit
Specialist Visit	$35 per visit
Lab tests and X-ray	Lab no charge, diagnostic xray no charge and therapeutic $20/$35
Specialized Imaging	$100 per procedure per body part
Outpatient Surgery	$100 copay
Allergy Testing	$20/35
Allergy Injections	$20 copay each visit
Preventive Care	
Well Child Care Office Visit	No charge up to 18 years old
Well Child Age limit	No charge up to 18 years old
Adult Routine Physical Exams	No charge for medically appropriate preventive care
Adult Immunizations	No charge for pneumonia, influenza, Hep B, covid-19
Routine Mammogram	No charge
Pap Smear	No charge
Prostate Screening (PSA)	No charge
Colon Cancer Screenings	No charge
Cardiovascular screenings	No charge
Hearing Evaluations	$20 copayment each visit
Inpatient Hospital	
Deductible per Confinement	None
Deductible per Day	None
Hospital Services	No copay per admission
Physicians and Surgeons' Services	Included in admission
Emergency Services	
Emergency Room Treatment	$90 waived if admitted
Non-emergency or non-urgent use of ER	Not covered
Ambulance	$25 per trip
Urgent Care Facility Services	$20 copay per visit
Physician Office Visit	$20 Copay per visits
After Hours	$20 copay per visit
Maternity Care	
Physician Office Visit	No charge
Maternity Care - Inpatient Delivery	No charge
Midwife delivery services	Include in hospital

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Mental Health	
Deductible per Confinement	None
Deductible per Day	None
Mental Health Inpatient	No copay per admission
Mental Health-Inpatient Plan Maximums	190-day lifetime limit in a psychiatric hospital
Mental Health Outpatient	$20/35 per visit
Mental Health - Group Therapy	$10 Copay
Mental Health-Outpatient Plan Maximums	None
Severe Mental Illness	No charge for inpatient; $20 per individual outpatient visit; $10 per group outpatient visit; 190 lifetime days psychiatric hospital
Substance Abuse	
Deductible per Confinement	None
Deductible per Day	None
Detoxification	No charge
Substance Abuse - Inpatient Treatment	No charge per inpatient admission with prior authorization if medically necessary and in compliance
Substance Abuse-Inpatient Plan Maximums	None
Substance Abuse-Outpatient	$20 copay Individual visit / $10 copay per group visit
Substance Abuse-Outpatient Plan Maximums	None
Rehabilitation Therapy	
Inpatient Rehabilitation	No charge
Outpatient Physical, Occupational, and Speech Therapy	$20 Copay
Alternative Care	
Chiropractic Care	$20 Copay up to 20 visits per period
Acupuncture	$15 Copay for 20 visits for Chronic Lower Back Pain
Acupressure	Not Covered
Massage Therapy	Not Covered
Other Services	
Private-Duty Nursing Care	No charge when medically necessary and authorized by a Plan physician for inpatient care
Durable Medical Equipment	No charge when prescribed by a Plan physician in accordance with Formulary guidelines
Prosthetic and Orthotic Appliances	No charge when prescribed by a Plan physician in accordance with Formulary guidelines
Smoking Cessation	No charge when prescribed by a Plan physician in accordance with Formulary guidelines
Weight control program	Covered by health education classes at no charge
Bariatric surgery	If determined medically necessary by a Plan physician, and program requirements are met, covered at $35 per visit, no charge for inpatient hospitalization
TMJ	If determined medically necessary by a Plan physician, and program requirements are met, covered at $35 per visit, no charge for inpatient hospitalization
Podiatry Services	Office copay and outpatient surgery cost sharing
Home Health Care	Covered at no charge
Skilled Nursing Facility Care	Covered up to 100 days per benefit period at no charge
Hospice Care	No charge covered per Medicare guidelines. Covered under original Medicare
Hearing Aids	Not Covered

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Family Planning	
Tubal ligation	$100 copay
Vasectomy	$100 copay
Contraceptive Drugs	$10 copay generic
Contraceptive Devices	100% covered
Infertility Testing	$20 copay
Infertility Treatments - Office Visit	$20 copay
Infertility Treatments - Surgery	$100 copay outpatient / No Charge inpatient
In Vitro Fertilization	Not covered
Infertility Treatments - Lifetime Maximum	None
Vision Care	
Eye Examination	$20 copay or $35 for specialist
Lenses	Not covered
Frames	Not covered
Contact lenses- necessary	Covered following surgery for Cataracts at no charge.
Contact lenses-elective	Not covered
Lasik Eye Surgery	Not covered
Organ and Tissue Transplants	
Organ Transplant -Inpatient	Covered at no charge
Organs covered	Heart, lung, heart/lung, liver, kidney, small bowel, pancreas, simultaneous pancreas/kidney and liver/kidney, cornea, and bone marrow, when transplant is determined to be medically necessary
Transplant Travel	Certain medical and hospital expenses are covered if approved by Health Plan and the expenses are directly related to the transplant
Transplant donor expenses	Certain medical and hospital expenses are covered if approved by Health Plan and the expenses are directly related to the transplant
Lifetime Maximum	Not Applicable
Prescription Drug Coverage	
Annual Prescription Deductible - Family	None
Annual Prescription Deductible - Individual	None
Out-of-Pocket Maximums - Individual	None
Out-of-Pocket Maximums - Family	None
Annual Maximum Benefit	None
Lifetime Maximum Benefit	None
Generic Substitution	Substitute as determined by provider
Retail Refill Penalty	N/A
Prescription Drug Retail	
Retail - Generic	$10 for 30 day supply
Retail - Brand Formulary	$30 for 30 day supply
Retail - Brand Non-Formulary	$30 for 30-day supply when approved
Single Source Brand	$30 for 30 day supply
Multi Source Brand	$30 for 30 day supply
Injectable Medications	$30 copay
Prescription Drug Mail Order	
Mail-Order - Generic	$20 for up to 90-day supply
Mail-Order - Brand Formulary	$60 for up to 90-day supply
Mail-Order - Brand Non-Formulary	$60 for up to 90-day supply when approved
Single Source Brand	$30 for 30-day retail or $60 for 90-day supply
Multi Source Brand	$60 for 90-day supply
Injectable Medications	$30 per injection
Day Supply	30 day retail, 90 day mail order
Other Services - Prescription Drugs	
Over the Counter	Not covered
Prenatal Vitamins	Not Covered
Diabetic Supplies	No charge for supplies to monitor blood glucose.
Lifestyle Drugs	Not Covered
Contraceptives - Injectable	$20 office visit copay
Fertility Drugs	not covered
Smoking Cessation	No charge for Medicare-covered smoking and tobacco use cessation preventive benefits
Cosmetic Medications	Not covered
Nutritional Supplements	Not covered