

**Summary of Benefits Chart for
Kaiser Permanente Senior Advantage (HMO) with Part D (7/1/21—6/30/22)**

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
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 No charge

Emergency Health Coverage You Pay

Emergency Department visits \$35 per visit
Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see “Hospitalization Services” for inpatient Cost Share)

Transportation 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 \$10 for up to a 100-day supply
Most brand-name items \$15 for up to a 100-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 No charge
Individual outpatient mental health evaluation and treatment \$10 per visit
Group outpatient mental health treatment \$5 per visit

continued

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
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
Hearing aid(s) every 36 months	Amount in excess of \$1,500 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
Meals delivered to your home following discharge from a hospital due to congestive heart failure	No charge up to two meals per day in a consecutive four-week period, once per calendar year

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 additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.