Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (7/1/22—6/30/23)

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	$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**
Outpatient surgery and certain other outpatient procedures	$5 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	$5 per visit
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: 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)	
Ambulance and Transportation Services	**You Pay**
Ambulance Services	No charge
Other transportation Services when provided by our designated transportation provider as described in this *EOC*	No charge for up to 24 one-way trips (50 miles per trip) per calendar year
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines	$5 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	$100 per admission
Individual outpatient mental health evaluation and treatment	$5 per visit
Group outpatient mental health treatment	$2 per visit

continued

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$100 per admission
Individual outpatient substance use disorder evaluation and treatment	$5 per visit
Group outpatient substance use disorder 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
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 or Skilled Nursing Facility	No charge up to three 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*.