

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

<b>Plan Out-of-Pocket Maximum</b>	
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	
<b>Plan Deductible</b>	None
<b>Professional Services (Plan Provider office visits)</b>	<b>You Pay</b>
Most Primary Care Visits and most Non-Physician Specialist Visits	No charge
Most Physician Specialist Visits .....	No charge
Annual Wellness visit and the “Welcome to Medicare” preventive visit .....	No charge
Routine physical exams .....	No charge
Routine eye exams with a Plan Optometrist .....	No charge
Urgent care consultations, evaluations, and treatment.....	No charge
Physical, occupational, and speech therapy .....	No charge
<b>Outpatient Services</b>	<b>You Pay</b>
Outpatient surgery and certain other outpatient procedures.....	No charge
Allergy injections (including allergy serum).....	No charge
Most immunizations (including the vaccine) .....	No charge
Most X-rays and laboratory tests .....	No charge
Manual manipulation of the spine .....	No charge
<b>Hospitalization Services</b>	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	No charge
<b>Emergency Health Coverage</b>	<b>You Pay</b>
Emergency Department visits .....	No charge
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)	
<b>Transportation Services</b>	<b>You Pay</b>
Ambulance Services .....	No charge
<b>Prescription Drug Coverage</b>	<b>You Pay</b>
Most covered outpatient items in accord with our drug formulary guidelines.....	\$5 for up to a 100-day supply
<b>Durable Medical Equipment (DME)</b>	<b>You Pay</b>
Covered durable medical equipment for home use .....	No charge
<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization .....	No charge
Individual outpatient mental health evaluation and treatment.....	No charge
Group outpatient mental health treatment .....	No charge
<b>Substance Use Disorder Treatment</b>	<b>You Pay</b>
Inpatient detoxification .....	No charge

continued

Individual outpatient substance use disorder evaluation and treatment.....	No charge
Group outpatient substance use disorder treatment.....	No charge

<b>Home Health Services</b>	<b>You Pay</b>
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Home health care (part-time, intermittent) .....	No charge
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<b>Other</b>	<b>You Pay</b>
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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 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*.