

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (10/1/22—9/30/23)

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 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

Outpatient Services

You Pay

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

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..... 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)

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..... No charge

Individual outpatient mental health evaluation and treatment..... No charge

Group outpatient mental health treatment..... No charge

continued

| Substance Use Disorder Treatment | | You Pay |
|---|--|---|
| Inpatient detoxification | | No charge |
| Individual outpatient substance use disorder evaluation and treatment..... | | No charge |
| Group outpatient substance use disorder treatment..... | | No charge |
| 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*.