

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/21—12/31/21)

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
 \$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) No charge
 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 \$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)

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 \$20 for up to a 100-day supply
 Most specialty drugs 20 percent Coinsurance (not to exceed \$100) for up to a 100-day supply

continued

| 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 |
| 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 \$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 |
| Ready-made meal delivery (2 meals per day, up to 4 weeks per calendar year, upon discharge from the hospital due to a primary diagnosis of congestive heart failure) | | No charge |
| 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 <i>Summary of Benefits</i> booklet enclosed; for a complete explanation, refer to the <i>EOC</i> . | | |