

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
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 at a Plan Pharmacy.....	\$5 for up to a 30-day supply, \$10 for a 31- to 60-day supply, or \$15 for a 61- to 100-day supply
Most generic refills through our mail-order service	\$5 for up to a 30-day supply or \$10 for a 31- to 100-day supply

continued

Most brand-name items at a Plan Pharmacy	\$10 for up to a 30-day supply, \$20 for a 31- to 60-day supply, or \$30 for a 61- to 100-day supply
Most brand-name refills through our mail-order service.....	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply

Durable Medical Equipment (DME)	You Pay
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Covered durable medical equipment for home use.....	No charge
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Mental Health Services	You Pay
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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
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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
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Home health care (part-time, intermittent).....	No charge
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Other	You Pay
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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*.