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

Kaiser Foundation Health Plan, Inc., Northern California Region
continues
Substance Use Disorder Treatment

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient detoxification</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Individual outpatient substance use disorder evaluation and treatment</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Group outpatient substance use disorder treatment</td>
<td>$2 per visit</td>
</tr>
</tbody>
</table>

Home Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (part-time, intermittent)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

Other

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglasses or contact lenses every 24 months</td>
<td>Amount in excess of $150 Allowance</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per benefit period)</td>
<td>No charge</td>
</tr>
<tr>
<td>External prosthetic and orthotic devices</td>
<td>No charge</td>
</tr>
<tr>
<td>Ostomy and urological supplies</td>
<td>No charge</td>
</tr>
<tr>
<td>Meals delivered to your home following discharge from a hospital or Skilled Nursing Facility</td>
<td>No charge up to three meals per day in a consecutive four-week period, once per calendar year</td>
</tr>
</tbody>
</table>

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.