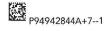
## Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (7/1/23—6/30/24)

Kaiser Permanente Senior Advantage (HMO) with	Part D (7/1/23—6/30/24)
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	.\$1,000 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	\$25 per visit
Most Physician Specialist Visits	\$25 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive	
visit	No charge
Routine physical exams	
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	
Physical, occupational, and speech therapy	\$25 per visit
Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by	
interactive video	
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by	
telephone	<u> </u>
Physician Specialist Visits by telephone	No charge
Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	
Most immunizations (including the vaccine)	
Most X-rays and laboratory tests	
Manual manipulation of the spine	\$20 per visit
Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests,	
and drugs	\$200 per admission
Emergency Health Coverage	You Pay
Emergency Department visits	
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 Services	You Pay
Ambulance Services	\$50 per trip
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	
	to the Commence

Kaiser Foundation Health Plan, Inc., Northern California Region



continues

Durable Medical Equipment (DME)	You Pay
Covered durable medical equipment for home use	
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	\$200 per admission
Individual outpatient mental health evaluation and treatment	
Group outpatient mental health treatment	\$12 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$200 per admission
Individual outpatient substance use disorder evaluation and	***
treatment	\$25 per visit
Group outpatient substance use disorder treatment	•
Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge
Other Control of the	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)	•
External prosthetic and orthotic devices	20 percent Coinsurance
Meals delivered to your home following discharge from a hospital	No charge up to two meals per day in
due to congestive beart failure	
due to congestive heart failure	

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*.