

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/24—12/31/24)

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	No charge
Routine eye exams with a Plan Optometrist	\$25 per visit
Urgent care consultations, evaluations, and treatment	\$25 per visit
Physical, occupational, and speech therapy	\$25 per visit

Telehealth Visits

You Pay

Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures.....	\$25 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	\$20 per visit

Hospital Inpatient Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$250 per admission
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Emergency Services

You Pay

Emergency department visits.....	\$50 per visit
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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 “Hospital Inpatient Services” for inpatient Cost Share)

Ambulance and Transportation Services

You Pay

Ambulance Services	\$50 per trip
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.....	\$10 for up to a 100-day supply
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Durable Medical Equipment (DME)	You Pay
Covered durable medical equipment for home use	20 percent Coinsurance
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	\$250 per admission
Individual outpatient mental health evaluation and treatment.....	\$25 per visit
Group outpatient mental health treatment	\$12 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$250 per admission
Individual outpatient substance use disorder evaluation and treatment.....	\$25 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
Hearing aid(s) every 36 months.....	Amount in excess of \$500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
External prosthetic and orthotic devices	20 percent Coinsurance
Meals delivered to your home immediately following discharge from a network hospital or Skilled Nursing Facility	No charge up to three meals per day in a consecutive four-week period, once per calendar year
Over-the-Counter (OTC) Health and Wellness products obtained through our OTC catalog	No charge for a quarterly benefit limit of \$70

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*.