600317 SOUTHERN CALIFORNIA EDISON COMPANY

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	$1,190 per calendar year

Annual Out-of-Pocket Maximum for Covered Part D Prescription Drugs	
For covered Part D prescription drugs, you will not pay any more Cost Share during a calendar year if the Coinsurance you pay exceeds:	$1,810 per Member, per calendar year

Plan Deductible	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$30 per visit
Most Physician Specialist Visits	$30 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	No charge
Urgent care consultations, evaluations, and treatment	$30 per visit
Physical, occupational, and speech therapy	$30 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	No charge
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

Emergency Services	You Pay
Emergency department visits	$135 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 “Hospital Inpatient Services” for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	No charge

continued

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	10 percent Coinsurance for up to a 100-day supply
Most brand-name items	20 percent Coinsurance 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	$250 per admission
Individual outpatient mental health evaluation and treatment	$30 per visit
Group outpatient mental health treatment	$15 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$250 per admission
Individual outpatient substance use disorder evaluation and treatment	$30 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)	$20 per day (up to 17 days) No charge (days 18–100)
External prosthetic and orthotic devices	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 *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.