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 one of the following amounts:	
For any one Member	$1,000 per calendar year
For any one Member in a Family of two or more Members	$1,000 per calendar year
For an entire Family of two or more Members	$2,000 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit
Most Physician Specialist Visits	$20 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	$20 per visit
Physical, occupational, and speech therapy	$20 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	$35 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	$100 per admission
Emergency Services	**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 "Hospital Inpatient 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

continues

continued

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
Most brand-name items at a Plan Pharmacy	$15 for up to a 30-day supply, $30 for a 31- to 60-day supply, or $45 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	$15 for up to a 30-day supply or $30 for a 31- to 100-day supply
Most specialty drugs	20 percent Coinsurance (not to exceed $100) for up to a 100-day supply

Note: For each covered insulin, you will not pay more than $35 for a 30-day supply, $70 for a 31- to 60-day supply, and $105 for a 61- to 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	$20 per visit
Group outpatient mental health treatment	$10 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$100 per admission
Individual outpatient substance use disorder evaluation and treatment	$20 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
Hearing aid(s) every 36 months	Amount in excess of $2,500 Allowance per aid, per ear
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
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

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*.