# Summary of Benefits Chart for 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 | $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 | $20 per visit |
| 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 | $50 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 |

| Hospitalization Services | You Pay |
|---|---|
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | $250 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 Services | You Pay |
|---|---|
| Ambulance Services | $100 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 | $35 for up to a 100-day supply |



*continues*

| 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 | $20 per visit |
| Group outpatient mental health treatment | $10 per visit |

| Substance Use Disorder Treatment | You Pay |
|---|---|
| Inpatient detoxification | $250 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 |
|---|---|
| Eyeglasses or contact lenses every 24 months | Amount in excess of $350 Allowance |
| 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 following discharge from a hospital due to congestive heart failure | No charge up to two 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*.