

## 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	\$10 per visit
Most Physician Specialist Visits .....	\$10 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 .....	\$10 per visit
Urgent care consultations, evaluations, and treatment .....	\$10 per visit
Physical, occupational, and speech therapy .....	\$10 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.....	\$10 per procedure
Most immunizations (including the vaccine) .....	No charge
Most X-rays and laboratory tests .....	No charge
Manual manipulation of the spine .....	\$10 per visit

### Hospital Inpatient Services You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	No charge
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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 Services You Pay

Ambulance Services .....	\$50 per trip
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### 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
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continued

<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization .....	No charge
Individual outpatient mental health evaluation and treatment.....	\$10 per visit
Group outpatient mental health treatment .....	\$5 per visit

  

<b>Substance Use Disorder Treatment</b>	<b>You Pay</b>
Inpatient detoxification .....	No charge
Individual outpatient substance use disorder evaluation and treatment.....	\$10 per visit
Group outpatient substance use disorder treatment.....	\$5 per visit

  

<b>Home Health Services</b>	<b>You Pay</b>
Home health care (part-time, intermittent) .....	No charge

  

<b>Other</b>	<b>You Pay</b>
Eyeglasses or contact lenses every 24 months.....	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
External prosthetic and orthotic devices .....	20 percent Coinsurance

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*.