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	$1,500 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	No charge
Most Physician Specialist Visits	No charge
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	No charge
Physical, occupational, and speech therapy	No charge
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	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
Note: If you are held for observation in a hospital unit or 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 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

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	$20 for up to a 30-day supply, $40 for a 31- to 60-day supply, or $60 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	$20 for up to a 30-day supply or $40 for a 31- 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	No charge
Individual outpatient mental health evaluation and treatment	No charge
Group outpatient mental health treatment	No charge
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$10 per visit
Group outpatient substance use disorder treatment	No charge
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 $175 Allowance
Hearing aid(s) every 36 months	Amount in excess of $1,000 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
Over-the-Counter (OTC) Health and Wellness products obtained Through our OTC catalog	No charge for a quarterly benefit limit of $70
Meals delivered to your home following discharge from a 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*.