Medicare Eligible / Post-65 Only	Kaiser Permanente Senior Advantage HMO - Northern & Southern California*	
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Plan Changes are in Orange	**2024 In-Network**	**Comments**
General Information		
Lifetime Maximum Benefit	None	
Annual Maximum Benefit	None	
Coinsurance Percentage	100% covered after applicable copay (80% covered for DME and P&O)	
Precertification Requirements	None	
Precertification Penalty	None	
Health Savings Account (HSA)	N/A	
Health Reimbursement Account (HRA)	N/A	
R & C	N/A	
Deductibles		
Individual Annual Deductible	None	
Family Annual Deductible	None	
Applies to Out-of-Pocket Maximum	N/A	
Prescription benefits are covered under medical deductible	N/A	
Out-of-Pocket Mx per Plan Year		
Individual Out-of-Pocket Maximum Per Year	**$1,000**	**Benefit Correction**
Family Out-of-Pocket Maximum Per Year	**$2,000**	**Benefit Correction**
Outpatient Services		
Primary Care Physician Visits	$15 per visit	
Specialist Visit	$15 per visit	
Lab tests and X-ray	No charge. $15 office visit copay may apply.	
Specialized Imaging	No charge	
Outpatient Surgery	$15 per procedure	
Allergy Testing	$15 per visit	
Allergy Injections	$3 per visit	
Preventive Care		
Well Child Care Office Visit	100% covered	
Well Child Age limit	23 months	
Adult Routine Physical Exams	100% covered	
Adult Immunizations	No charge for immunizations; office visit copay may apply	
Routine Mammogram	No charge	
Pap Smear	100% covered	
Prostate Screening (PSA)	100% covered	
Colon Cancer Screenings	100% covered	
Cardiovascular screenings	100% covered	
Hearing Evaluations	Preventive: 100% covered; Diagnostic: $15 copay	
Inpatient Hospital		
Deductible per Confinement	None	
Deductible per Day	None	
Hospital Services	$200 per admission	
Physicians and Surgeons' Services	Included in $200 per admission inpatient copay	

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Emergency Services		
Emergency Room Treatment	$50 per visit** **Does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition	
Non-emergency or non-urgent use of ER	$50 per visit; Non-emergency or non-urgent use of ER is not covered	
Ambulance	$50 per trip, when determined to meet the criteria that define an emergency	
Urgent Care Facility Services	$15 per visit	
Physician Office Visit	Included in $50 ER copay	
After Hours	$15 per Urgent Care visit; $50 per ER visit	
Maternity Care		
Physician Office Visit	No charge	
Maternity Care - Inpatient Delivery	$200 per admission	
Midwife delivery services	Included in $200 inpatient admission copay; at facilities where available	
Mental Health		
Deductible per Confinement	None	
Deductible per Day	None	
Mental Health Inpatient	$200 per admission	
Mental Health-Inpatient Plan Maximums	None	
Mental Health Outpatient	$15 per individual visit	
Mental Health - Group Therapy	$7 per group visit	
Mental Health-Outpatient Plan Maximums	Unlimited	
Severe Mental Illness	$200 per admission for inpatient; $15 per individual outpatient visit; $7 per group outpatient visit; no day or visit limits.	
Substance Abuse		
Deductible per Confinement	None	
Deductible per Day	None	
Detoxification	$200 per admission	
Substance Abuse - Inpatient Treatment	$200 per admission to Transitional Residential Recovery Services (TRRS) in a non-medical setting	
Substance Abuse-Inpatient Plan Maximums	No day limits, in compliance with MHPA	
Substance Abuse-Outpatient	$15 per individual visit; $5 per group visit	
Substance Abuse-Outpatient Plan Maximums	Unlimited	
Rehabilitation Therapy		
Inpatient Rehabilitation	Included in $200 per admission inpatient copay	
Outpatient Physical, Occupational, and Speech Therapy	$15 copay per visit. Benefits are limited to medically necessary therapy authorized by a Plan physician.	
Alternative Care		
Chiropractic Care	$15 per visit***** *****$15 per visit for manual manipulation of the spine only; $15 per visit, up to 30 visits per calendar year with American Specialty Health Plans chiropractic rider	
Acupuncture	$15 per visit when approved by a Plan physician, generally as a component of a multidisciplinary pain management program for the treatment of chronic pain	
Acupressure	Not covered	
Massage Therapy	Not covered	

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Other Services		
Private-Duty Nursing Care	Not covered, except when deemed medically necessary by a Plan physician for inpatient care	
Durable Medical Equipment	20% coinsurance when prescribed by a Plan physician in accordance with Medicare and Formulary guidelines	
Prosthetic and Orthotic Appliances	20% coinsurance when prescribed by a Plan physician in accordance with Formulary guidelines	
Smoking Cessation	Covered health education classes are at no charge. Smoking cessation drugs are covered the same as other drugs when members participate in a behavioral health class.	
Weight control program	Covered health education classes are at no charge	
Bariatric surgery	If determined medically necessary by a Plan physician, and program requirements are met, covered at $15 per visit, $200 per admission for inpatient hospitalization	
TMJ	Inpatient: $200 copay per admission; Outpatient: $15 copay per encounter. Must be deemed medically necessary. (i.e., etiology must be medical not dental)	
Podiatry Services	$15 per visit when medically necessary	
Home Health Care	No charge when prescribed by a Plan physician for part-time intermittent care	
Skilled Nursing Facility Care	No charge, up to 100 days per benefit period	
Hospice Care	No charge for Members without Medicare Part A (see Evidence of Coverage for details for Members with Medicare Part A)	
Hearing Aids	Not covered	
Family Planning		
Tubal ligation	$15 per outpatient procedure; $200 per admission for inpatient surgery after appropriate counseling.	
Vasectomy	$15 per outpatient procedure; $200 per admission for inpatient surgery after appropriate counseling.	
Contraceptive Drugs	Covered under outpatient prescription benefit	
Contraceptive Devices	$20 copay for diaphragm or cervical cap; no charge for IUD	
Infertility Testing	$15 per visit; no charge for lab	
Infertility Treatments - Office Visit	$15 per visit	
Infertility Treatments - Surgery	$15 per outpatient procedure; $200 per admission for inpatient surgery	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Treatment for involuntary infertility is covered as authorized by a Plan physician	
Vision Care		
Eye Examination	Preventive: 100% covered; Diagnostic: $15 copay	
Lenses	$150 eyewear allowance every 24 months for frames and lenses OR elective contact lenses	
Frames	$150 eyewear allowance every 24 months for frames and lenses OR elective contact lenses	
Contact lenses- necessary	When prescribed by a Plan physician, no charge for contact lenses to treat aniridia (missing iris), up to two lenses per eye every 12 months. When prescribed by a Plan physician for aphakia (absence of the crystalline lens of the eye), no charge for up to 6 lenses per eye every 12 months, through age 9	
Contact lenses-elective	$150 eyewear allowance every 24 months for frames and lenses OR elective contact lenses	
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants		
Organ Transplant -Inpatient	$200 per admission	
Organs covered	Heart, lung, heart/lung, liver, kidney, small bowel, pancreas, simultaneous pancreas/kidney and liver/kidney, cornea, and bone marrow, when transplant is determined to be medically necessary	
Transplant Travel	Covered when pre-authorized by the Plan physician and related to the provision of covered services, in accordance with Plan policies	
Transplant donor expenses	Certain medical and hospital expenses are covered if approved by Health Plan and the expenses are directly related to the transplant	
Lifetime Maximum	None	

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Prescription Drug Coverage		
Annual Prescription Deductible - Family	None	
Annual Prescription Deductible - Individual	None	
Out-of-Pocket Maximums - Individual	N/A	
Out-of-Pocket Maximums - Family	N/A	
Annual Maximum Benefit	Unlimited	
Lifetime Maximum Benefit	Unlimited	
Generic Substitution	Determined by patient's Plan physician	
Retail Refill Penalty	None	
Prescription Drug Retail		
Retail - Generic	$10 per prescription, up to a 30-day supply All prescriptions must be medically necessary, prescribed by a Plan physician, and obtained from a Plan pharmacy of from Plan mail order to be covered	
Retail - Brand Formulary	$20 per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies	
Retail - Brand Non-Formulary	$20 per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies	
Single Source Brand	$20 per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies	
Multi Source Brand	$20 per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies	
Injectable Medications	$10 (generic)/$20 (brand) per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies	
Prescription Drug Mail Order		
Mail-Order - Generic	$10 for up to a 30-day supply, or $20 for a 31 to 100-day supply	
Mail-Order - Brand Formulary	$20 for up to 30-day supply, or $40 for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order	
Mail-Order - Brand Non-Formulary	$20 for up to 30-day supply, or $40 for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order	
Single Source Brand	$20 for up to 30-day supply, or $40 for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order	
Multi Source Brand	$20 for up to 30-day supply, or $40 for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order	
Injectable Medications	$10 (generic)/$20 (brand) per prescription for up to 30-day supply, or $20 (generic)/$40 (brand) per prescription for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order	
Day Supply	Up to 100	
Other Services - Prescription Drugs		
Over the Counter	Not covered	
Prenatal Vitamins	Not covered	
Diabetic Supplies	Insulin: $20 copay for up to 100-day supply; Testing supplies: 80% covered up to 100-day supply in accordance with DME Medicare and formulary guidelines	
Lifestyle Drugs	Drugs for the treatment of impotency are 75% covered with a maximum dosage limit of 27 doses for 100-day supply.	
Contraceptives - Injectable	Covered at no charge when dispensed in Plan Medical Offices	
Fertility Drugs	Covered at applicable prescription copay	
Smoking Cessation	Covered at applicable prescription copay if prescribed by a Plan physician and patient is concurrently participating in a Plan-approved behavioral modification program	
Cosmetic Medications	Not covered	
Nutritional Supplements	Not covered	