

Kaiser Permanente Senior Advantage (HMO)

Summary of Medical Benefits Part D

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Member Services: **1-877-221-8221 (TTY 711)**
8 a.m. to 8 p.m., 7 days a week

Oregon C25H

1/1/2025 - 12/31/2025

City of San Jose

Group Number: 4189-001

Deductible	
For one Member per Year	None
Out-of-Pocket Maximum¹	
For one Member per Year	\$600
Office visits	
You pay	
Welcome to Medicare preventive visit	\$0
Primary Care	\$25
Specialty Care ^{2†}	\$25
Urgent Care	\$25
Tests (outpatient)	
You pay	
Preventive Tests	\$0
Laboratory ^{2†}	\$0
X-ray, imaging, and special diagnostic procedures ^{2†}	\$0
CT, MRI, PET scans ^{2†}	\$0
Medications (outpatient)	
You pay	
Prescription drugs [†]	\$10 generic/\$25 brand, for up to a 30-day supply, per prescription. When you get your drugs from our mail-order pharmacy, you may get up to a 31-90 day supply for two copayments. Insulin is subject to the applicable drug tier cost-sharing up to \$35 for each 30-day supply. After you have paid \$2,000 out-of-pocket for Part D covered drugs in a calendar year, you pay nothing for the remainder of the year.
Administered medications, including injections (all outpatient settings) [†]	15% Coinsurance

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Nurse treatment room visits to receive injections [†]	\$5
Hospital Services	You pay
Ambulance Services (per transport)	\$50
Emergency department visit	\$50
Inpatient Hospital Services ^{2†}	\$0
Outpatient Services (other)	You pay
Outpatient surgery visit ^{2†}	\$25
Chemotherapy/radiation therapy visit ^{2†}	\$25
Durable medical equipment [†]	\$0
Physical, speech, and occupational therapies ^{2†}	\$25
Skilled Nursing Facility Services	You pay
Inpatient skilled nursing Services up to 100 days per Medicare Benefit Period ^{2†}	\$0
Mental Health and Substance Abuse Services[†]	You pay
Outpatient Services	\$25
Inpatient Services	\$0
Alternative Care (self-referred)	You pay
Acupuncture Services	Not covered
Chiropractic Services	Not covered
Massage Therapy	Not covered
Naturopathic Medicine	Not covered
Vision Services	You pay
Routine eye exam	\$25
Vision hardware and optical Services	Balance after \$150 allowance to use toward the purchase price of eyewear once within a two-calendar-year period.
Outside Service Area Benefit	20%. The annual benefit maximum is \$1,250. Kaiser Permanente pays 80% up to \$1,000 per year. You pay 100% thereafter. (In the U.S. only.)
One Pass®	\$0 for basic fitness center membership at participating centers.
Hearing Aids²	Balance after \$500 allowance is applied for each hearing aid per ear every three years

¹ Refer to your Medical Benefits Chart for cost-sharing that does not apply to the out-of-pocket maximum.

² Your plan provider may need to provide a referral.

† Prior authorization may be required.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request.

Have questions?

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- 7 days a week, 8 a.m. to 8 p.m.

The benefit information provided is a brief summary, not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. If you receive Extra Help to pay for Medicare Part D prescription drug coverage, premiums and cost sharing will vary based on the level of Extra Help you receive. Please contact the plan for further details.