Individual KPSA Medicare Plans & Rates

	Marin (Basic)	*Marin (Enhanced)*
Monthly Premium	**Check with Kaiser**	**Check with Kaiser**
Annual OOPM	$6,700.00	$4,900.00
Doctor Office Visit Copay	$20.00	$10.00
Emergency Room Copay	$90.00	$90.00
Urgent Care Copay	$20.00	$10.00
Inpatient Hospitalization*	$310.00	$240.00
Outpatient Surgery Copay	$300.00	$200.00
Lab	$0.00	$0.00
X-Ray	$30.00	$20.00
DME	20%	20%
Ambulance Service (Per 1-way trip)	$20.00	$200.00
Skilled Nursing Facility Care**		
Days 1 through 20	$0.00	$0.00
Days 21 through 100	$100.00	$100.00
Home Health Care (part time/intermittent)	$0.00	$0.00
Eyeglasses or contact lenses (every 24 months)	Amount in excess of $40	Amount in excess of $40
Rx Preferred Generic (30 Days)	$6.00	$3.00
Rx Generic (30 Days)	$18.00	$12.00
Rx Preferred Brand (30 Days)	$47.00	$47.00
Rx Brand (30 Days)	$100.00	$100.00
Rx Specialty (30 Days)	33%	33%
Gap† Rx Preferred Generic (30 Days)	$6.00	$3.00
Gap† Rx Generic (30 Days)	$18.00	$12.00
Gap† Brand/Specialty	25%	25%
Chiropractic/Acupuncture Copay	Not covered	Not covered
Post-discharge Meal Delivery	Not included	Not included
Routine & Post-Discharge Transportation (24 one-way trips, up to 50 miles per trip)	Not included	Not included

10/1/2023 - 9/30/2024 SISC K PSA Medicare Plan & Rates

NCR $10	*NCR $25*	
$281.00	$231.00	**Monthly Premium**
$1,500.00	$1,500.00	**Annual OOPM**
$10.00	$25.00	**Doctor Office Visit Copay**
$50.00	$50.00	**Emergency Room Copay**
$10.00	$25.00	**Urgent Care Copay**
$0.00	$500.00	**Inpatient Hospitalization**
$10.00	$25.00	**Outpatient Surgery Copay**
$0.00	$0.00	**Lab**
$0.00	$0.00	**X-Ray**
0%	20%	**DME**
$50.00	$150.00	**Ambulance Service** (Per 1-way trip)
		Skilled Nursing Facility Care**
$0.00	$0.00	**Days 1 through 20**
$0.00	$0.00	**Days 21 through 100**
$0.00	$0.00	**Home Health Care (part time/intermittent)**
Amount in excess of $150	Amount in excess of $150	**Eyeglasses or contact lenses (every 24 months)**
$10.00	$10.00	**Rx Most Generic (100 Days)**
$20.00	$25.00	**Rx Most Brand (100 Days)**
$20.00	$25.00	**Rx Specialty** (100 Days)
N/A	N/A	**Gap† Rx Preferred Generic** (30 Days)
N/A	N/A	**Gap† Rx Generic** (30 Days)
N/A	N/A	**Gap† Brand/Specialty**
$10.00	$10.00	**Chiropractic/Acupuncture Copay**
Included	Included	**Post-discharge Meal Delivery (3 meals/day up to 4 weeks)**
Included	Included	**Routine & Post-Discharge Transportation (24 one-way trips, up to 50 miles per trip)**

*Per day for days 1-5 of your stay. Thereafter, no charge for the remainder of your stay

**Plan covers up to 100 days per benefit period. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row.

†If your annual out-of-pocket costs reach $4,430, you move into the Coverage Gap Stage (Gap). You pay 25% for brand-name & specialty drugs (including a portion of the dispensing fee). If your annual out-of-pocket costs reach $7050, you move into the Catastrophic Coverage Stage.