Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/27—12/31/27)

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	$2,500 per calendar year
Plan Deductible	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 per visit
Most Physician Specialist Visits	$25 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	$15 per visit
Urgent care consultations, evaluations, and treatment	$15 per visit
Physical, occupational, and speech therapy	$15 per visit
Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge
Physician Specialist Visits by interactive video or telephone	No charge
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$100 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$15 per visit
Preventive services as described in the *EOC*	No charge
Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per admission
Emergency Services and Care	**You Pay**
Emergency department visits	$50 per visit
Ambulance Services	**You Pay**
Ambulance Services	$100 per trip
Transportation	**You Pay**
Rides provided to and from a plan provider by taxis, rideshare services, vans, and medical transport as determined by our designated transportation provider	No charge for 24 one-way trips (up to 50 miles per trip) per calendar year
Medically necessary, non-emergency medical transportation to home (within 100 miles), a skilled nursing facility (SNF), or another higher level of care, immediately following an inpatient hospitalization or after certain emergency, urgent care, or outpatient hospital encounters, **when ordered by a network provider**. Refer to the *EOC* for more details	No charge

Prescription Drug Coverage	**You Pay**
This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.	
Initial coverage stage—until you have spent $2,400 in 2027. (If you spend $2,400, you move on to the catastrophic coverage stage):	
Generic drugs at a pharmacy	$15 for up to a 30-day supply, $30 for a 31- to 60-day supply, or $45 for a 61- to 100-day supply
Generic refills through our mail-order service	$15 for up to a 30-day supply or $30 for a 31- to 100-day supply
Brand-name drugs at a pharmacy	$30 for up to a 30-day supply, $60 for a 31- to 60-day supply, or $90 for a 61- to 100-day supply
Brand-name refills through our mail-order service	$30 for up to a 30-day supply or $60 for a 31- to 100-day supply
Catastrophic coverage stage	No charge
In addition, this plan also covers Medicare Part B drugs and drugs not covered by Medicare in accord with our commercial formulary (see the *EOC* for details).	

Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	20 percent Coinsurance

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$250 per admission
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$250 per admission
Individual outpatient substance use disorder evaluation and treatment	$15 per visit
Group outpatient substance use disorder treatment	$5 per visit

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 $100 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	20 percent Coinsurance
Meals delivered to your home immediately following discharge from a network hospital or Skilled Nursing Facility	No charge up to three meals per day in a consecutive four-week period, once per calendar year
Fitness benefit – One Pass® (includes access to in-network gyms and one home fitness kit per calendar year)	No charge

Summary of Benefits **booklet**

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*.