

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\$1,000 per calendar year

Plan Deductible

None

Plan Provider Office Visits

You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits \$20 per visit

Most Physician Specialist Visits \$20 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 \$20 per visit

Urgent care consultations, evaluations, and treatment \$20 per visit

Physical, occupational, and speech therapy \$20 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 \$20 per procedure

Most immunizations (including the vaccine) No charge

Most X-rays and laboratory tests No charge

Manual manipulation of the spine \$20 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 \$100 per admission

Emergency Services and Care

You Pay

Emergency department visits \$50 per visit

Ambulance Services

You Pay

Ambulance Services No charge

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

Transportation	You Pay
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 <i>EOC</i> 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: \$10 for up to a 100-day supply Brand-name drugs: \$35 for up to a 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 <i>EOC</i> for details).	
Durable Medical Equipment (DME)	You Pay
Covered durable medical equipment for home use	No charge
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	\$100 per admission
Individual outpatient mental health evaluation and treatment	\$20 per visit
Group outpatient mental health treatment	\$10 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$100 per admission
Individual outpatient substance use disorder evaluation and treatment	\$20 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 \$150 Allowance
Hearing aid(s) every 36 months	Amount in excess of \$2,500 Allowance for each ear
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
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*.