

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/26—12/31/26)

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

Professional Services (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

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

Hospital Inpatient Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs No charge

Emergency Services

You Pay

Emergency department visits \$50 per visit

Ambulance and Transportation Services

You Pay

Ambulance Services \$50 per trip

Other transportation Services when provided by our designated transportation provider as described in this *EOC* No charge for up to 24 one-way trips (50 miles per trip) per calendar year

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 \$2,100 in 2026. (If you spend \$2,100, you move on to the catastrophic coverage stage) Generic drugs: \$10 for up to a 100-day supply
Brand-name drugs: \$20 for up to a 100-day supply

Catastrophic coverage stage No charge

Durable Medical Equipment (DME)

You Pay

Covered durable medical equipment for home use No charge

Mental Health Services

You Pay

Inpatient psychiatric hospitalization No charge

Individual outpatient mental health evaluation and treatment \$20 per visit

continued

Mental Health Services		You Pay
Group outpatient mental health treatment		\$10 per visit
Substance Use Disorder Treatment		You Pay
Inpatient detoxification		No charge
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 \$175 Allowance
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
Over-the-Counter (OTC) Health and Wellness products obtained through our OTC catalog		No charge for a quarterly benefit limit of \$70
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*.