

**Summary of Benefits Chart for
Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/25—12/31/25)**

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 \$1,500 per calendar year

Plan Deductible **None**

Professional Services (Plan Provider office visits) **You Pay**

Most Primary Care Visits and most Non-Physician Specialist Visits	No charge
Most Physician Specialist Visits	No charge
Annual Wellness visit and the “Welcome to Medicare” preventive visit	No charge
Routine physical exams.....	No charge
Routine eye exams with a Plan Optometrist.....	No charge
Urgent care consultations, evaluations, and treatment.....	No charge
Physical, occupational, and speech therapy.....	No charge

Outpatient Services **You Pay**

Outpatient surgery and certain other outpatient procedures.....	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	No charge

Hospital Inpatient Services **You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
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Emergency Services **You Pay**

Emergency department visits	\$50 per visit
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Ambulance and Transportation Services **You Pay**

Ambulance Services.....	No charge
Other transportation Services when provided by our designated transportation provider as described in this <i>EOC</i>	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 \$2,000 in 2025. (If you spend \$2,000, you move on to the catastrophic coverage stage):

Generic drugs at a pharmacy	\$5 for up to a 30-day supply, \$10 for a 31- to 60-day supply, or \$15 for a 61- to 100-day supply
Generic refills through our mail-order service	\$5 for up to a 30-day supply or \$10 for a 31- to 100-day supply
Brand-name drugs at a pharmacy	\$20 for up to a 30-day supply, \$40 for a 31- to 60-day supply, or \$60 for a 61- to 100-day supply

Prescription Drug Coverage		You Pay
Brand-name refills through our mail-order service		\$20 for up to a 30-day supply or \$40 for a 31- to 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.....		No charge
Group outpatient mental health treatment		No charge
Substance Use Disorder Treatment		You Pay
Inpatient detoxification.....		No charge
Individual outpatient substance use disorder evaluation and treatment		No charge
Group outpatient substance use disorder treatment.....		No charge
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
Hearing aid(s) every 36 months		Amount in excess of \$1,000 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*.