

Kaiser Permanente

# Kaiser Permanente Senior Advantage Alam., SF, Napa (HMO)

**Plan type:** Medicare Advantage with drug coverage

**Plan ID:** H0524-032-0

[Plan website](#) | Non-members: 1-800-777-1238 | Members: 1-800-443-0815

## What you'll pay

Total monthly premium	Health deductible	Primary doctor copay	2026 estimated total drug costs (lowest cost pharmacy)
\$99.00	\$0.00	\$0	\$0.00

Covers 4 of 4 drugs  
[View drug coverage](#)

## Overview

### PREMIUMS

Total monthly premium	\$99.00
Health premium	\$95.60
Drug premium	\$3.40
Standard Part B premium <a href="#">What's the standard Part B premium?</a>	\$202.90
Part B premium reduction <a href="#">What's the Part B premium reduction?</a>	Not offered

### DEDUCTIBLES

The amount you must pay each year before your plan starts to pay for covered services or drugs.

Health deductible	\$0.00
Drug deductible	\$0.00

## MAXIMUM YOU PAY FOR HEALTH SERVICES

### Maximum you pay for health services ^

Once you spend this amount for covered services in a year, your plan pays 100% for your care.

\$3,900 In-network

## CONTACT INFORMATION

### Plan address

One Kaiser Plaza  
Oakland, CA 94612

# Benefits & Costs

## DOCTOR SERVICES

### View Provider Network Directory

Primary doctor visit	In-network: \$0 copay	
Specialist visit	In-network: \$15 copay	<u>Limits apply</u> ^  <b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

## TESTS, LABS, & IMAGING

### Diagnostic tests & procedures ^

Tests done to confirm or uncover the presence of an illness or disease.

In-network: \$0 copay

Limits apply ^

**Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

**Lab services**

In-network: \$0 copay

[Limits apply ^](#)

**Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

**Diagnostic radiology services (like MRI)**

In-network: \$10-\$275 copay

[Limits apply ^](#)

**Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

**Outpatient x-rays**

In-network: \$10 copay

[Limits apply ^](#)

**Physician Referral Required** - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

**Emergency care**

\$150 copay

**Urgent care**

\$0 copay

## HOSPITAL SERVICES

Inpatient hospital coverage	Tier 1 \$270 per day for days 1-5 \$0 per day for days 6-90 \$0 per stay	<u>Limits apply</u> ^  <b>Advanced Plan Approval Required</b> - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.  <b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Outpatient hospital coverage	In-network: \$0-\$240 copay	

## SKILLED NURSING FACILITY

Skilled nursing facility	Tier 1 \$0 per day for days 1-20 \$100 per day for days 21-100	<u>Limits apply</u> ^  <b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
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## PREVENTIVE SERVICES

Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (like Pap tests, flu shots, and screening mammograms).

[Learn more about your costs for preventive services](#)

Preventive services	In-network: \$0 copay	<a href="#">Limits apply</a> ^  <b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
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## AMBULANCE

Ground ambulance	In-network: \$350 copay	
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## THERAPY SERVICES

Occupational therapy visit	In-network: \$5-\$10 copay	<a href="#">Limits apply</a> ^  <b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Physical therapy & speech & language therapy visit	In-network: \$0-\$10 copay	<a href="#">Limits apply</a> ^  <b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.

## MENTAL HEALTH SERVICES

Outpatient group therapy with a psychiatrist	In-network: \$0 copay	
Outpatient individual therapy with a psychiatrist	In-network: \$0 copay	
Outpatient group therapy visit	In-network: \$0 copay	
Outpatient individual therapy visit	In-network: \$0 copay	

## OPIOID TREATMENT PROGRAM SERVICES

Opioid treatment program services	In-network: \$0 copay	<a href="#"><u>Limits apply</u></a> ^  <b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
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## OTHER SERVICES

Durable medical equipment (like wheelchairs & oxygen)	In-network: 0%-20% coinsurance	<a href="#">Limits apply</a> ^  <b>Advanced Plan Approval Required</b> - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.
Prosthetics (like braces, artificial limbs)	In-network: 20% coinsurance	<a href="#">Limits apply</a> ^  <b>Advanced Plan Approval Required</b> - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.
Dialysis	In-network: 20% coinsurance	<a href="#">Limits apply</a> ^  <b>Advanced Plan Approval Required</b> - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.
Diabetes supplies	In-network: \$0 copay	<a href="#">Limits apply</a> ^  <b>Advanced Plan Approval Required</b> - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.



# Drug Coverage

[See if there's help to lower costs for drugs you take.](#)

## MY DRUG LIST

	Package	Quantity	Frequency	Brand/Generic
Atorvastatin calcium 10mg tablet		60	Every 2 months	Generic
Buspirone hcl 7.5mg tablet		30	Every month	Generic
Finasteride 5mg tablet		90	Every 3 months	Generic
Paroxetine hcl 10mg tablet		30	Every month	Generic

## PHARMACIES

Check the network status of each pharmacy on your list. You can change pharmacies at any time to find lower costs for drugs.

KAISER HEALTH PLAN OHLONE PHY 162	 In-network
WALGREENS #2660	 Out-of-network

## YEARLY DRUG COSTS BY PHARMACY

Drug costs shown vary based on the plan and pharmacy that you use. Contact the plan if you have specific questions about drug costs. [Can my drug costs change by pharmacy?](#)

	Kaiser Health Plan Ohlone Phy 162  In-network	Walgreens #2660  Out-of-network
Atorvastatin calcium 10mg tablet	\$0.00	\$1,426.44
Buspirone hcl 7.5mg tablet	\$0.00	\$557.52
Finasteride 5mg tablet	\$0.00	\$1,103.08
Paroxetine hcl 10mg tablet	\$0.00	\$923.88
Total yearly drug cost	\$0.00	\$4,010.92

## ESTIMATED TOTAL DRUG + PREMIUM COST

	Kaiser Health Plan Ohlone Phy 162  In-network	Walgreens #2660  Out-of-network
Total drug + premium cost (for 2026)	\$1,188.00	\$5,198.92

## ESTIMATED TOTAL MONTHLY DRUG COST

	Kaiser Health Plan Ohlone Phy 162  In-network	Walgreens #2660  Out-of-network
January	\$0.00	\$636.96
February	\$0.00	\$123.45
March	\$0.00	\$361.19
April	\$0.00	\$399.22
May	\$0.00	\$361.19
June	\$0.00	\$123.45
July	\$0.00	\$636.96
August	\$0.00	\$123.45
September	\$0.00	\$361.19
October	\$0.00	\$399.22
November	\$0.00	\$361.19
December	\$0.00	\$123.45

## ESTIMATED DRUG COSTS

The drug prices shown may vary based on the plan and pharmacy you've selected. Contact the plan if you have specific questions about drug costs.

**For 2026, you won't pay more than \$2,100 out-of-pocket for covered Part D drugs.**

[Learn more about why your costs change.](#)

– KAIser Health Plan Ohlone Phy 162 - Drug Costs During Coverage Phases

	Retail cost	Cost after deductible	Cost after out-of-pocket cap
Atorvastatin calcium 10mg tablet	\$9.04	\$0.00	\$0.00
Buspirone hcl 7.5mg tablet	\$6.01	\$0.00	\$0.00
Finasteride 5mg tablet	\$15.00	\$0.00	\$0.00
Paroxetine hcl 10mg tablet	\$7.02	\$0.00	\$0.00
<b>Monthly totals</b>	<b>\$37.07</b>	<b>\$0.00</b>	<b>\$0.00</b>

– Walgreens #2660 - Drug Costs During Coverage Phases

You may have to pay the full cost for drugs. Choose an in-network pharmacy to get drugs at a lower cost. [Find an in-network pharmacy.](#)

	Retail cost	Cost after deductible	Cost after out-of-pocket cap
Atorvastatin calcium 10mg tablet	\$237.74	\$237.74	\$237.74
Buspirone hcl 7.5mg tablet	\$46.46	\$46.46	\$46.46
Finasteride 5mg tablet	\$275.77	\$275.77	\$275.77
Paroxetine hcl 10mg tablet	\$76.99	\$76.99	\$76.99
<b>Monthly totals</b>	<b>\$636.96</b>	<b>\$636.96</b>	<b>\$636.96</b>

#### COSTS BY DRUG TIER

Each plan has a list of drugs they cover (called a “formulary”). Drugs on the list can be grouped into tiers with different cost levels. Some plans don’t use tiers. Below is what you’ll pay for drugs in each tier, based on your coverage phase.

[Learn more about drug tiers.](#)

Tiers	Initial coverage phase	Catastrophic coverage phase
Preferred Generic	\$0.00 copay	\$0 copay
Generic	\$7.00 copay	\$0 copay
Preferred Brand	\$47.00 copay	\$0 copay
Non-Preferred Drug	\$100.00 copay	\$0 copay
Specialty Tier	32% coinsurance	\$0 copay
Vaccines	\$0.00 copay	\$0 copay

#### OTHER DRUG INFORMATION

	Tier	Prior authorization	Quantity limits	Step therapy
Atorvastatin calcium 10mg tablet	Tier 1	–	–	–
Buspirone hcl 7.5mg tablet	Tier 1	–	–	–
Finasteride 5mg tablet	Tier 1	–	–	–
Paroxetine hcl 10mg tablet	Tier 1	–	–	–

#### PART B DRUGS

These are drugs you usually get at a doctor's office or hospital outpatient setting, like the flu shot, chemotherapy, or other shots.

Part B insulin	In-network: \$7-\$35 copay	
Chemotherapy drugs	In-network: \$0-\$47 copay, 0%-20% coinsurance	
Other Part B drugs	In-network: \$0-\$47 copay, 0%-20% coinsurance	

## Extra Benefits

## HEARING

Hearing exam	Not covered	
Fitting/evaluation	Not covered	
Hearing aids - prescription	Not covered	
Hearing aids - over the counter	Not covered	

## PREVENTIVE DENTAL

Care to prevent or find problems with your teeth and gums.

Oral exam	In-network: \$0 copay	<a href="#"><u>Limits apply</u></a> 
		<b>Advanced Plan Approval Required</b> - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.  <b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.  <b>Plan limits</b> - There may be limits on how much the plan will provide.

## Cleaning

In-network: \$0 copay

[Limits apply ^](#)

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## Fluoride treatment

In-network: \$0 copay

[Limits apply ^](#)

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**Plan limits** - There may be limits on how much the plan will provide.

## Dental x-rays

In-network: \$0 copay

[Limits apply ^](#)

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**Plan limits** - There may be limits on how much the plan will provide.

## COMPREHENSIVE DENTAL

Care to maintain or treat problems with your teeth and gums.

Restorative services	Not covered	
Endodontics	Not covered	
Periodontics	In-network: \$0 copay	<a href="#">Limits apply ^</a> <p><b>Advanced Plan Approval Required</b> - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.</p> <p><b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.</p> <p><b>Plan limits</b> - There may be limits on how much the plan will provide.</p>

Prosthodontics, removable	Not covered	
Prosthodontics, fixed	Not covered	
Maxillofacial prosthetics	Not covered	
Implant services	Not covered	
Oral and maxillofacial surgery	Not covered	
Orthodontics	Not covered	
Adjunctive general services	In-network: \$0 copay	<p><u>Limits apply</u> ^</p> <p><b>Advanced Plan Approval Required</b> - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.</p> <p><b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.</p>

## VISION

Routine eye exam	In-network: \$0 copay	<u>Limits apply</u> ^  <b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
Contact lenses	Not covered	
Eyeglasses (frames & lenses)	Not covered	
Eyeglass frames only	Not covered	
Eyeglass lenses only	Not covered	
Upgrades	Not covered	

## MEDICALLY-APPROVED NON-OPIOID PAIN MANAGEMENT SERVICES

Chiropractic services	Not covered	
Acupuncture	In-network: \$0 copay	<a href="#"><u>Limits apply</u></a> 
		<b>Advanced Plan Approval Required</b> - A process through which the physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to an enrollee. Unless specified otherwise with respect to a particular item or service, the enrollee is not responsible for obtaining (prior) authorization.
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		<b>Plan limits</b> - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.
Massage therapy	Not covered	
Alternative therapies	Not covered	

## MORE BENEFITS

Health Education	In-network: \$0 copay	<a href="#"><u>Limits apply</u></a> 
		<b>Physician Referral Required</b> - A process through which the enrollee's primary care physician or other network physician (depending on the plan policy) permits or instructs the enrollee to obtain an item or service from another physician or other provider type.
		<b>Plan limits</b> - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.
Counseling Services	Not covered	

Support for Caregivers of Enrollees	Not covered	
Personal Emergency Response System (PERS)	Not covered	
Fitness benefit	Not covered	
Transportation services for non-emergency care: Any health-related locations	Not covered	
Transportation services for non-emergency care: Plan-approved locations	Not covered	
Over the counter drug benefits	In-network: \$0 copay	<p><a href="#">Limits apply</a> ^</p> <p><b>Plan limits</b> - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.</p>
In-home support services	Not covered	
Home and bathroom safety devices	Not covered	
Meals for short duration	Not covered	
Annual physical exams	In-network: \$0 copay	<p><a href="#">Limits apply</a> ^</p> <p><b>Plan limits</b> - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.</p>
Telehealth	In-network: \$0 copay	<p><a href="#">Limits apply</a> ^</p> <p><b>Plan limits</b> - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.</p>
Worldwide emergency	\$150 copay	<p><a href="#">Limits apply</a> ^</p> <p><b>Plan limits</b> - There may be limits, like the number of times you can use the item or service or how much the plan will cover. Contact the plan for details.</p>

Post discharge in-home medication reconciliation	Not covered
Re-admission prevention	Not covered
Wigs for hair loss related to chemotherapy	Not covered
Weight management programs	Not covered
Adult day health services	Not covered
Home-based palliative care	Not covered

## Optional Packages

This plan includes optional benefits you can add to your coverage at an additional cost.

**Package #1** Includes wellness programs, preventive dental services, comprehensive dental services, eyewear, hearing exams, and hearing aids

**Monthly premium:** \$20.00

**Deductible:** N/A

## Star Ratings

+ Expand All Ratings

### Overall star rating



Overall rating is based on the categories below.

### + Health plan star rating



### Summary rating of health plan quality

### + Drug plan star rating



### Summary rating of drug plan quality

Feedback

## Providers

[View Provider Network Directory](#)

Add Provider

## Find participating providers

Add your providers to find out if they participate in this plan.