
Benefit Summary**152 CONTRA COSTA COUNTY****Principal Benefits for****Kaiser Permanente Senior Advantage (HMO) (1/1/22—12/31/22) (HMO B)****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 \$25 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..... \$25 per visit

Urgent care consultations, evaluations, and treatment..... \$25 per visit

Physical, occupational, and speech therapy..... \$25 per visit

Outpatient Services**You Pay**

Outpatient surgery and certain other outpatient procedures..... \$25 per procedure

Allergy injections (including allergy serum)..... No charge

Most immunizations (including the vaccine) No charge

Most X-rays and laboratory tests..... No charge

Manual manipulation of the spine \$20 per visit

Hospitalization Services**You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs \$250 per admission

Emergency Health Coverage**You Pay**

Emergency Department visits..... \$50 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see “Hospitalization Services” for inpatient Cost Share)

Ambulance Services**You Pay**

Ambulance Services..... \$50 per trip

Prescription Drug Coverage**You Pay**

Covered outpatient items in accord with our drug formulary guidelines at a Plan Pharmacy or through our mail-order service:

Most generic items..... \$10 for up to a 100-day supply

Most brand-name items \$20 for up to a 100-day supply

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..... \$25 per visit

Group outpatient mental health treatment \$12 per visit

Substance Use Disorder Treatment**You Pay**

Inpatient detoxification..... \$250 per admission

Substance Use Disorder Treatment		You Pay
Individual outpatient substance use disorder evaluation and treatment		\$25 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
Skilled nursing facility care (up to 100 days per benefit period).....		No charge
External prosthetic and orthotic devices		20 percent Coinsurance
Ostomy and urological supplies.....		20 percent Coinsurance
Meals delivered to your home following discharge from a hospital due to congestive heart failure		No charge up to two meals per day in a consecutive four-week period, once per calendar year

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*.