

**Benefit Summary**

**230179 CITY OF SAN JOSE**

**Principal Benefits for  
Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/22—12/31/22)**

**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 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

Most covered outpatient items in accord with our drug formulary guidelines ..... \$10 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

**Benefit Summary***(continued)*

<b>Substance Use Disorder Treatment</b>	<b>You Pay</b>
Individual outpatient substance use disorder evaluation and treatment .....	\$25 per visit
Group outpatient substance use disorder treatment.....	\$5 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (part-time, intermittent) .....	No charge
<b>Other</b>	<b>You Pay</b>
Eyeglasses or contact lenses every 24 months.....	Amount in excess of \$150 Allowance
Hearing aid(s) every 36 months .....	Amount in excess of \$500 Allowance per aid
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 or Skilled Nursing Facility .....	No charge up to three 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*.