
Proposed Benefit Summary

229297 COUNTY OF SANTA BARBARA

**Principal Benefits for
Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/17—12/31/17)**

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary and in accord with Medicare guidelines
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area, except where specifically noted to the contrary in the *Evidence of Coverage (EOC)*

Accumulation Period

The Accumulation Period for this plan is 1/1/17 through 12/31/17 (calendar year).

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 one of the following amounts:

For self-only enrollment (a Family of one Member)	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 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
Hearing exams	\$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	\$50 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays, annual mammograms, 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	\$500 per admission
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Emergency Health Coverage

You Pay

Emergency Department visits	\$50 per visit
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Ambulance Services

You Pay

Ambulance Services	\$100 per trip
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Proposed Benefit Summary

(continued)

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	\$10 for up to a 100-day supply
Most brand-name items.....	\$35 for up to a 100-day supply
Durable Medical Equipment (DME)	You Pay
Covered durable medical equipment for home use	No charge
Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	\$500 per admission
Individual outpatient mental health evaluation and treatment	\$20 per visit
Group outpatient mental health treatment	\$10 per visit
Chemical Dependency Services	You Pay
Inpatient detoxification	\$500 per admission
Individual outpatient chemical dependency evaluation and treatment.....	\$20 per visit
Group outpatient chemical dependency 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
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	No charge
Ostomy and urological supplies	No charge

This is a summary of the most frequently asked-about benefits. 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 a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).