

603194 COUNTY OF MARIN EMPLOYEES - PLAN S

**Principal Benefits for
Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/19—12/31/19)**

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
..... \$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 No charge
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) \$3 per visit
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 No charge

Emergency Health Coverage You Pay

Emergency Department visits \$50 per visit

Ambulance Services You Pay

Ambulance Services \$50 per trip

Prescription Drug Coverage You Pay

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items at a Plan Pharmacy \$10 for up to a 30-day supply, \$20 for a 31- to 60-day supply, or \$30 for a 61- to 100-day supply
Most generic refills through our mail-order service \$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply

(continued)

Most brand-name items at a Plan Pharmacy.....	\$25 for up to a 30-day supply, \$50 for a 31- to 60-day supply, or \$75 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	\$25 for up to a 30-day supply or \$50 for a 31- to 100-day supply

Durable Medical Equipment (DME) You Pay

Covered durable medical equipment for home use	20 percent Coinsurance
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Mental Health Services You Pay

Inpatient psychiatric hospitalization.....	No charge
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	No charge
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
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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	No charge
Ostomy and urological supplies	No charge

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 more information, please refer to the *Summary of Benefits* booklet enclosed.