Proposed Benefit Summary

KAISER PERMANENTE®

Customer Name: **Alameda County Employees Retirement Association**
Customer ID: **7668 – Northern California – Retirees**

Principal Benefits for Retirees
Kaiser Permanente Senior Advantage Plan (2/1/22—1/31/23)

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$10 per visit
Routine physical maintenance exams, including Annual Wellness visit	No charge
Routine eye exams with a Plan Optometrist	$10 per visit
Urgent care consultations, evaluations, and treatment	$10 per visit
Most physical, occupational, and speech therapy	$10 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy antigens (including administration)	$3 per injection
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge
MRI, most CT, and PET scans	No charge

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	$25 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	No charge

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply

Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	No charge

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit

Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$10 per visit
Group outpatient substance use disorder treatment	$5 per visit

(continues)

Proposed Benefit Summary *(continued)*

Home Health Services	You Pay
Home health care (part-time, intermittent care)	No charge

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Hospice care	No charge
Hearing aids	$1,000 allowance every 36 months
Optical hardware	$150 allowance every 24 months

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).