

**SISC - Self-Insured Schools of California**

**Principal Benefits for  
Kaiser Permanente Senior Advantage (HMO) with Part D (10/1/19—9/30/20)**

**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

..... \$10 per visit

Most Physician Specialist Visits .....

\$10 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 .....

\$10 per visit

Urgent care consultations, evaluations, and treatment .....

\$10 per visit

Physical, occupational, and speech therapy .....

\$10 per visit

**Outpatient Services**

**You Pay**

Outpatient surgery and certain other outpatient procedures .....

\$10 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 .....

\$10 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 ..... \$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 .....

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
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 .....	20 percent Coinsurance
Ostomy and urological supplies .....	20 percent Coinsurance

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.