SISC-SELF INSURED
SCHOOLS OF CALIFORNIA

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (10/1/26—9/30/27)

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	$1,000 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	No charge
Most Physician Specialist Visits	No charge
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	No charge
Physical, occupational, and speech therapy	No charge
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	No charge
Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Services	**You Pay**
Emergency department visits	$50 per visit
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**
This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.	
Initial coverage stage—until you have spent $2,100 in 2026. (If you spend $2,100, you move on to the catastrophic coverage stage)	$5 for up to a 100-day supply
Catastrophic coverage stage	No charge
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	No charge

continued

Mental Health Services	You Pay
Group outpatient mental health treatment	No charge

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	No charge
Group outpatient substance use disorder treatment	No charge

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 for each ear
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
Meals delivered to your home immediately following discharge from a network hospital or Skilled Nursing Facility	No charge up to three meals per day in a consecutive four-week period, once per calendar year
Fitness benefit – One Pass® (includes access to in-network gyms and one home fitness kit per calendar year)	No charge

Your Kaiser Permanente Combined Chiropractic and Acupuncture Benefit

Benefit Highlights

Professional Services (ASH Participating Provider office visits)	You Pay
Chiropractic and acupuncture office visits (up to a combined total of 30 visits per 12-month period)	$10 per visit

Other	You Pay
X-rays and laboratory tests that are covered Chiropractic Services	No charge
Chiropractic supports and appliances	Amounts in excess of the $50 Allowance

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, refer to the Combined Chiropractic and Acupuncture Services amendment to your Health Plan *EOC*

***Summary of Benefits* booklet**

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*. 420976.20.1