**FRESNO UNIFIED SCHOOL DISTRICT**
**Group ID: 603815 - DHMO XD**
**Member Services 1-800-443-0815**

# Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/27—12/31/27)

| **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 |
| **Plan Provider Office Visits** | **You Pay** |
| Most Primary Care Visits and most Non-Physician Specialist Visits | $15 per visit |
| Most Physician Specialist Visits | $15 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 | $15 per visit |
| Physical, occupational, and speech therapy | $15 per visit |
| **Telehealth Visits** | **You Pay** |
| Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone | No charge |
| Physician Specialist Visits by interactive video or telephone | No charge |
| **Outpatient Services** | **You Pay** |
| Outpatient surgery and certain other outpatient procedures | $50 per procedure |
| Most immunizations (including the vaccine) | No charge |
| Most X-rays and laboratory tests | No charge |
| Manual manipulation of the spine | $15 per visit |
| Preventive services as described in the *EOC* | No charge |
| **Hospital Inpatient Services** | **You Pay** |
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | $500 per admission |
| **Emergency Services and Care** | **You Pay** |
| Emergency department visits | $50 per visit |
| **Ambulance Services** | **You Pay** |
| Ambulance Services | $100 per trip |
| **Transportation** | **You Pay** |
| Rides provided to and from a plan provider by taxis, rideshare services, vans, and medical transport as determined by our designated transportation provider | No charge for 24 one-way trips (up to 50 miles per trip) per calendar year |

*continued*

| **Transportation** | **You Pay** |
|---|---|
| Medically necessary, non-emergency medical transportation to home (within 100 miles), a skilled nursing facility (SNF), or another higher level of care, immediately following an inpatient hospitalization or after certain emergency, urgent care, or outpatient hospital encounters, **when ordered by a network provider**. Refer to the *EOC* for more details | No charge |
| **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 $2,400 in 2027. (If you spend $2,400, you move on to the catastrophic coverage stage) | Generic drugs: $10 for up to a 100-day supply<br>Brand-name drugs: $35 for up to a 100-day supply |
| ***Catastrophic coverage stage*** | No charge |
| In addition, this plan also covers Medicare Part B drugs and drugs not covered by Medicare in accord with our commercial formulary (see the *EOC* for details). | |
| **Durable Medical Equipment (DME)** | **You Pay** |
| Covered durable medical equipment for home use | 20 percent Coinsurance |
| **Mental Health Services** | **You Pay** |
| Inpatient psychiatric hospitalization | $500 per admission |
| Individual outpatient mental health evaluation and treatment | $15 per visit |
| Group outpatient mental health treatment | $7 per visit |
| **Substance Use Disorder Treatment** | **You Pay** |
| Inpatient detoxification | $500 per admission |
| Individual outpatient substance use disorder evaluation and treatment | $15 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 |
| Skilled nursing facility care (up to 100 days per benefit period) | No charge |
| External prosthetic and orthotic devices | 20 percent Coinsurance |
| 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 |

## ***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*.