225543 SISC-Self Insured Schools of California – $1,000 Hospital Only Deductible - DHMO

Principal Benefits for Kaiser Permanente Deductible HMO Plan (10/1/13—9/30/14)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$3,000 per calendar year
For any one Member in a Family of two or more Members	$3,000 per calendar year
For an entire Family of two or more Members	$6,000 per calendar year

Deductible for Certain Services	
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:	
For self-only enrollment (a Family of one Member)	$1,000 per calendar year
For any one Member in a Family of two or more Members	$1,000 per calendar year
For an entire Family of two or more Members	$2,000 per calendar year
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$20 per visit (Deductible doesn't apply)
Routine physical maintenance exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$20 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	$20 per visit (Deductible doesn't apply)
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Deductible
Allergy injections (including allergy serum)	No charge (Deductible doesn't apply)
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter (Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure (Deductible doesn't apply)
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	20% Coinsurance after Deductible
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip (Deductible doesn't apply)

(continues)

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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 (Deductible doesn't apply)
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 (Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply, $60 for a 31- to 60-day supply, or $90 for a 61- to 100-day supply (Deductible doesn't apply)
Most brand-name refills through our mail-order service	$30 for up to a 30-day supply or $60 for a 31- to 100-day supply (Deductible doesn't apply)
Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance after Deductible
Individual outpatient mental health evaluation and treatment	$20 per visit (Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Deductible doesn't apply)
Chemical Dependency Services	**You Pay**
Inpatient detoxification	20% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment	$20 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance (Deductible doesn't apply)
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge (Deductible doesn't apply)
All Services related to covered infertility treatment	50% Coinsurance (Deductible doesn't apply)
Hospice care	No charge (Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).