
Proposed Benefit Summary

600115 SISC - Self-Insured Schools of California-\$500 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 Northern 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)	\$500 per calendar year
For any one Member in a Family of two or more Members.....	\$500 per calendar year
For an entire Family of two or more Members	\$1,000 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	10% 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 <i>EOC</i>	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	10% Coinsurance after Deductible
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Emergency Health Coverage

You Pay

Emergency Department visits	10% Coinsurance after Deductible
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Ambulance Services

You Pay

Ambulance Services	\$150 per trip (Deductible doesn't apply)
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Proposed Benefit Summary

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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.....	10% 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	10% 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).....	10% 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).