
Proposed Benefit Summary

225543 SISC-Self Insured Schools of California-\$500 Hospital Only Deductible DHMO w/Chiro

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

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

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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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)
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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)
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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)
Chiropractor	\$10 per visit, 30 visits per year (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).