Disclosure Form

SISC - Self-insured Schools of California

Home Region: California

Principal benefits for Kaiser Permanente Traditional HMO Plan

(10/1/18—9/30/19)

Family Coverage

Entire Family of two or more

Members

\$3,000

Accumulation Period

The Accumulation Period for this plan is 1/1/18 through 12/31/18 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

Amounts Per Accumulation Period

Plan Out-of-Pocket Maximum

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation

Self-Only Coverage

(a Family of one Member)

\$1,500

Family Coverage

Each Member in a Family of

two or more Members

\$1,500

Period once you have reach	ed the amounts listed below.
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Fian Out-of-Focket Maximum	φ1,300	φ1,500	φ3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None
Professional Services (Plan Provider off	ice visits)	You Pay	
Most Primary Care Visits and most Non-Ph Most Physician Specialist Visits	t	\$20 per visit No charge No charge No charge No charge No charge \$20 per visit \$20 per visit You Pay \$20 per procedure No charge No charge No charge No charge No charge No charge	
Covered health education programs Hospitalization Services		No charge You Pay	
Room and board, surgery, anesthesia, X-ra	avs. laboratory tests, and drugs	•	
Emergency Health Coverage		You Pay	
Emergency Department visits Note: This Cost Share does not apply if you "Hospitalization Services" for inpatient Co	u are admitted directly to the hospital as st Share).		d Services (see
		•	
Ambulance Services		•	
Prescription Drug Coverage		You Pay	
Covered outpatient items in accord with ou Most generic items at a Plan Pharmacy of Most brand-name items at a Plan Pharm Most specialty items at a Plan Pharmacy	or through our mail-order serviceacy or through our mail-order service	\$20 for up to a 100-da	ny supply
Durable Medical Equipment (DME)		You Pay	
DME items as described in the EOC		No charge	
Mental Health Services		You Pay	
Inpatient psychiatric hospitalizationIndividual outpatient mental health evaluating Group outpatient mental health treatment	on and treatment	\$20 per visit	
Substance Use Disorder Treatment		You Pay	
Inpatient detoxificationIndividual outpatient substance use disorder troup outpatient substance use disorder tr	er evaluation and treatment	\$20 per visit	
			(continues)

Disclosure Form	(continued)	
Home Health Services	You Pay	
Home health care (up to 100 visits per Accumulation Period)	No charge	
Other	You Pay	
Eyeglasses or contact lenses every 24 months		

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, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).