

**Disclosure Form Part One**

SISC - Self-Insured Schools of California  
Home Region: California

**Principal benefits for  
Kaiser Permanente Traditional HMO Plan**

(10/1/21—9/30/22)

**Accumulation Period**

The Accumulation Period for this plan is January 1 through December 31.

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

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 Period once you have reached the amounts listed below.

| <b>Amounts Per Accumulation Period</b> | <b>Self-Only Coverage<br/>(a Family of one Member)</b> | <b>Family Coverage<br/>Each Member in a Family of<br/>two or more Members</b> | <b>Family Coverage<br/>Entire Family of two or more<br/>Members</b> |
|--|--|---|---|
| Plan Out-of-Pocket Maximum             | \$1,500  | \$1,500   | \$3,000   |
| Plan Deductible                        | None   | None  | None  |
| Drug Deductible                        | None   | None  | None  |

**Professional Services (Plan Provider office visits)**

|   | <b>You Pay</b> |
|---|----------------|
| Most Primary Care Visits and most Non-Physician Specialist Visits ..... | \$10 per visit |
| Most Physician Specialist Visits.....                                   | \$10 per visit |
| Routine physical maintenance exams, including well-woman exams .....    | No charge      |
| Well-child preventive exams (through age 23 months).....                | No charge      |
| Family planning counseling and consultations .....                      | No charge      |
| Scheduled prenatal care exams .....                                     | No charge      |
| Routine eye exams with a Plan Optometrist.....                          | No charge      |
| Urgent care consultations, evaluations, and treatment.....              | \$10 per visit |
| Most physical, occupational, and speech therapy .....                   | \$10 per visit |

**Outpatient Services**

|  | <b>You Pay</b>     |
|--|--------------------|
| Outpatient surgery and certain other outpatient procedures ..... | \$10 per procedure |
| Allergy antigens (including administration) .....                | No charge          |
| Most immunizations (including the vaccine) .....                 | No charge          |
| Most X-rays and laboratory tests .....                           | No charge          |

**Hospitalization Services**

|   | <b>You Pay</b> |
|---|----------------|
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs..... | No charge      |

**Emergency Health Coverage**

|   | <b>You Pay</b>  |
|---|-----------------|
| Emergency Department visits.....  | \$100 per visit |
| Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share) |                 |

**Ambulance Services**

|                          | <b>You Pay</b> |
|--------------------------|----------------|
| Ambulance Services ..... | \$50 per trip  |

**Prescription Drug Coverage**

|  | <b>You Pay</b>                  |
|--|---------------------------------|
| Covered outpatient items in accord with our drug formulary guidelines:           |                                 |
| Most generic items at a Plan Pharmacy or through our mail-order service .....    | \$10 for up to a 100-day supply |
| Most brand-name items at a Plan Pharmacy or through our mail-order service ..... | \$10 for up to a 100-day supply |
| Most specialty items at a Plan Pharmacy .....                                    | \$10 for up to a 30-day supply  |

**Durable Medical Equipment (DME)**

|   | <b>You Pay</b> |
|---|----------------|
| DME items as described in the EOC ..... | No charge      |

**Mental Health Services**

|   | <b>You Pay</b> |
|---|----------------|
| Inpatient psychiatric hospitalization .....                       | No charge      |
| Individual outpatient mental health evaluation and treatment..... | \$10 per visit |
| Group outpatient mental health treatment .....                    | \$5 per visit  |

**Substance Use Disorder Treatment**

|  | <b>You Pay</b> |
|--|----------------|
| Inpatient detoxification .....   | No charge      |
| Individual outpatient substance use disorder evaluation and treatment..... | \$10 per visit |
| Group outpatient substance use disorder treatment.....                     | \$5 per visit  |

**Home Health Services**

|  | <b>You Pay</b> |
|--|----------------|
| Home health care (up to 100 visits per Accumulation Period)..... | No charge      |

**Other**

|                                     | <b>You Pay</b>                              |
|-------------------------------------|---|
| Hearing aid(s) every 36 months..... | Amount in excess of \$500 Allowance per aid |

(continues)

**Disclosure Form Part One**

(continued)

| <b>Other</b>   | <b>You Pay</b>   |
|--|--|
| Skilled nursing facility care (up to 100 days per benefit period) .....  | No charge  |
| Prosthetic and orthotic devices as described in the <i>EOC</i> .....   | No charge  |
| Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i> ..... | the Cost Share you would pay if the Services were to treat any other condition |
| Assisted reproductive technology (“ART”) Services .....  | Not covered  |
| Hospice care.....  | No charge  |

| <b>Chiropractic and Acupuncture Coverage (through ASH Plans)</b> | <b>You Pay</b> |
|--|----------------|
|--|----------------|

|   |                      |
|---|----------------------|
| Up to a combined total of 30 Chiropractic and Acupuncture visits per year ..... | \$10 copay per visit |
|---|----------------------|

Kaiser Permanente contracts with American Specialty Health Plans (ASH) to provide chiropractic and acupuncture care. Members must receive all their benefits from ASH Plans participating providers. ASH Plans contracts with Participating Providers and other licensed providers to provide covered Chiropractic Services (including laboratory tests, X-rays, and chiropractic appliances). ASH Plans contracts with Participating Providers to provide acupuncture care (including adjunctive therapies, such as acupressure, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture). You must receive covered Services from a Participating Provider or another licensed provider with which ASH contracts, except for Emergency Chiropractic Services, Emergency Acupuncture Services, Urgent Chiropractic Services, and Urgent Acupuncture Services, and Services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered Services that are authorized in advance by ASH Plans.

The list of Participating Providers is available on the ASH Plans website at [www.ashlink.com/ash/kp](http://www.ashlink.com/ash/kp) or from the ASH Plans Customer Service Department at **1-800-678-9133**. The list of Participating Providers is subject to change at any time without notice.

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).