
Disclosure Form One**234480 SISC-SELF INSURED SCHOOLS OF CALIFORNIA****Principal Benefits for****Kaiser Permanente HSA-Qualified High Deductible Health Plan (“HDHP”) HMO (1/1/25—9/30/25)**

“Kaiser Permanente HSA-Qualified High Deductible Health Plan (“HDHP”) HMO” is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the *EOC*.

Accumulation Period

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

Out-of-Pocket Maximums and Deductibles

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.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	\$3,500	\$3,500	\$7,000
Plan Deductible	\$1,700	\$3,300	\$3,400
Drug Deductible	Not applicable	Not applicable	Not applicable

Plan Provider Office Visits**You Pay**

Most Primary Care Visits and most Non-Physician Specialist Visits	10% Coinsurance after Plan Deductible
Most Physician Specialist Visits	10% Coinsurance after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist.....	10% Coinsurance (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	10% Coinsurance after Plan Deductible
Most physical, occupational, and speech therapy	10% Coinsurance after Plan Deductible

Telehealth Visits**You Pay**

Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge after Plan Deductible
Physician Specialist Visits by interactive video or telephone	No charge after Plan Deductible

Outpatient Services**You Pay**

Outpatient surgery and certain other outpatient procedures	10% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	10% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i>	No charge (Plan Deductible doesn't apply)

Hospital Inpatient Services**You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	10% Coinsurance after Plan Deductible
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Emergency Services**You Pay**

Emergency department visits	10% Coinsurance after Plan Deductible
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 “Hospital Inpatient Services” for inpatient Cost Share)	

Ambulance Services**You Pay**

Ambulance Services	10% Coinsurance after Plan Deductible
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Prescription Drug Coverage**You Pay**

Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	\$10 for up to a 30-day supply after Plan Deductible
Most generic (Tier 1) refills through our mail-order service	\$20 for up to a 100-day supply after Plan Deductible
Most brand-name items (Tier 2) at a Plan Pharmacy	\$30 for up to a 30-day supply after Plan Deductible
Most brand-name (Tier 2) refills through our mail-order service	\$60 for up to a 100-day supply after Plan Deductible

Prescription Drug Coverage	You Pay
Most specialty items (Tier 4) at a Plan Pharmacy	\$30 for up to a 30-day supply after Plan Deductible
Durable Medical Equipment (DME)	You Pay
Base DME items as described in the <i>EOC</i>	10% Coinsurance after Plan Deductible
Supplemental DME items up to a \$2,500 benefit limit per Accumulation Period as described in the <i>EOC</i>	10% Coinsurance after Plan Deductible
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	10% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	10% Coinsurance after Plan Deductible
Group outpatient mental health treatment	10% Coinsurance after Plan Deductible
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	10% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	10% Coinsurance after Plan Deductible
Group outpatient substance use disorder treatment	10% Coinsurance after Plan Deductible
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge after Plan Deductible
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	10% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge after Plan Deductible
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

This proposal is a summary and does not include all benefits, member cost share, out-of-pocket maximums, exclusions, or limitations. For a complete description, please refer to the *Evidence of Coverage*.