Benefit Summary

132731 SANTA ANA UNIFIED SCHOOL DISTRICT

Principal Benefits for
Kaiser Permanente Traditional HMO Plan (7/1/19—6/30/20)

Accumulation Period

The Accumulation Period for this plan is 1/1/19 through 12/31/19 (calendar year).

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.

<table>
<thead>
<tr>
<th>Amounts Per Accumulation Period</th>
<th>Self-Only Coverage (a Family of one Member)</th>
<th>Family Coverage Each Member in a Family of two or more Members</th>
<th>Family Coverage Entire Family of two or more Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Out-of-Pocket Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Drug Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Professional Services (Plan Provider office visits)

Most Primary Care Visits and most Non-Physician Specialist Visits........................................... $20 per visit
Most Physician Specialist Visits........................................................................................................... $20 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 ............................................................................... $20 per visit
Most physical, occupational, and speech therapy ....................................................................................... $20 per visit

Outpatient Services

Outpatient surgery and certain other outpatient procedures ....................................................................... $20 per procedure
Allergy injections (including allergy serum) ................................................................................................. No charge
Most immunizations (including the vaccine).................................................................................................. No charge
Most X-rays and laboratory tests ................................................................................................................ No charge
Covered individual health education counseling ......................................................................................... No charge
Covered health education programs .......................................................................................................... No charge

Hospitalization Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs................................................. $250 per admission

Emergency Health Coverage

Emergency Department visits ....................................................................................................................... $150 per visit
Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services

Ambulance Services................................................................................................................................. No charge

Prescription Drug Coverage

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
  Most generic refills through our mail-order service ..................................................................................... $20 for up to a 100-day supply
  Most brand-name items at a Plan Pharmacy ................................................................................................ $20 for up to a 30-day supply
  Most brand-name refills through our mail-order service ........................................................................... $40 for up to a 100-day supply
  Most specialty items at a Plan Pharmacy ................................................................................................... $20 for up to a 30-day supply

Durable Medical Equipment (DME)

DME items as described in the EOC ............................................................................................................. No charge

Mental Health Services

Inpatient psychiatric hospitalization ........................................................................................................... $250 per admission
Individual outpatient mental health evaluation and treatment ................................................................. $20 per visit
Group outpatient mental health treatment .................................................................................................. $10 per visit

Substance Use Disorder Treatment

Inpatient detoxification ............................................................................................................................... $250 per admission

(continues)
### Benefit Summary

<table>
<thead>
<tr>
<th>Substance Use Disorder Treatment</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual outpatient substance use disorder evaluation and treatment</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Group outpatient substance use disorder treatment</td>
<td>$5 per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Health Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (up to 100 visits per Accumulation Period)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility care (up to 100 days per benefit period)</td>
<td>No charge</td>
</tr>
<tr>
<td>Prosthetic and orthotic devices as described in the <em>EOC</em></td>
<td>No charge</td>
</tr>
<tr>
<td>Hospice care</td>
<td>No charge</td>
</tr>
</tbody>
</table>

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).