Effective October 1, 2023

PLAN NAME	Kaiser HMO (SISC) $10 Copay
Individual/Family Deductibles	$0 / $0
Individual/Family Calendar Out-of-Pocket Max *(includes medical co-pays, deductibles and co-insurance)*	$1,500 / $3,000

PROFESSIONAL SERVICES

Office Visit co-pay	$10
Urgent Care co-pay	$10
Specialists/Consultants co-pay	$10
Prenatal, postnatal office visit co-pay	$0
Scans: CT, CAT, MRI, PET etc.	$0
Diagnostic X-ray & Laboratory Procedures	$0
Infertility (diagnosis/treatment of causes of infertility)	Covered [1]
Preventive Care Services (includes physical exams & screenings)	$0

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit co-pay (waived if admitted)	$100
Inpatient Hospital co-pay	$0
Outpatient Hospital co-pay	$10
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	$10
Surgery, Outpatient (performed in a Hospital)	$10

MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT

INPATIENT CARE: Facility based care (preauthorization required)	$0
OUTPATIENT CARE: Facility based care (preauthorization required)	Ind: $10 | Group: $5

OTHER SERVICES

Acupuncture - Limits apply	$10 (30 visits/year, combined)
Ambulance (Ground or Air)	$50
Chiropractic - Limits apply	$10 (30 visits/year, combined)
Durable Medical Equipment (DME)	$0
Physical and Occupational Therapy - Limits apply	$10
Vision Allowance	$150
Vision Exam	$0

PRESCRIPTION DRUG PLANS

Provider Network	Kaiser
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	Included w/ Med OOP Max
Tier/Generic 1 co-pay/days supply	$10 (100-day supply)
Tier 2/Brand co-pay/days supply	$10 (100-day supply)
Mail Order (Generic-Brand co-pay/days supply)	$10 / $10 (100-day supply)

[1] The Cost Share you would pay if the Services were to treat any other condition

Note: This is a brief benefit summary that reflects in-network benefits from a participating or contracted provider. For additional details, limitations, exclusions and out-of-network coverage, please refer to the Summary of Benefits or Coverage Booklet.