



Customer Name: Schools Insurance Group
Customer ID: 602214

Benefit Plan 2481
TYPE HSA; \$2000 DED;\$30 OUTP;
\$250 INPT;\$30/\$10 RX

Proposed Benefit Summary

Principal Benefits for Kaiser Permanente \$2,000 Deductible Plan with HSA Option (July 1, 2010 — June 30, 2011)

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, visiting Member care, hospice care, Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

"Kaiser Permanente \$2,000 Deductible Plan with HSA Option" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in the *EOC* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

Annual Out-of-Pocket Maximum

You will not pay any more Cost Sharing during a calendar year if the Copayments, Coinsurance, and Deductible amounts you pay for Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	\$3,000 per calendar year
For an entire Family of two or more Members	\$6,000 per calendar year

Deductible for all Services except certain preventive Services as specified below

You must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:

For self-only enrollment (a Family of one Member)	\$2,000 per calendar year
For an entire Family of two or more Members	\$4,000 per calendar year

Note: The Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.

Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

Routine preventive care:

Physical exams	\$30 per visit (Deductible doesn't apply)
Well-child visits (through age 23 months)	\$10 per visit (Deductible doesn't apply)
Family planning visits	\$30 per visit after Deductible
Scheduled prenatal care visits	\$10 per visit (Deductible doesn't apply)
Eye exams for refraction	\$30 per visit after Deductible
Hearing tests	\$30 per visit after Deductible
Flexible sigmoidoscopies	\$30 per visit (Deductible doesn't apply)

Primary and specialty care visits

\$30 per visit after Deductible

Urgent care visits

\$30 per visit after Deductible

Voluntary termination of pregnancy

\$30 per procedure after Deductible

Physical, occupational, and speech therapy

\$30 per visit after Deductible

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	\$150 per procedure after Deductible
Allergy injection visits	\$5 per visit after Deductible
Allergy testing visits	\$30 per visit after Deductible
Most vaccines (immunizations)	No charge (Deductible doesn't apply)
X-rays and lab tests	\$10 per encounter after Deductible (except the Deductible doesn't apply to preventive screenings as described in the <i>EOC</i>)
MRI, CT and PET	\$50 per procedure after Deductible
Health education:	
Individual visits	\$30 per visit (Deductible doesn't apply)
Group educational programs	No charge (Deductible doesn't apply)

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$250 per admission after Deductible
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Emergency Health Coverage	You Pay
Emergency Department visits	\$100 per visit after Deductible
Ambulance Services	You Pay
Ambulance Services	\$100 per trip after Deductible
Prescription Drug Coverage	You Pay
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy	\$10 for up to a 30-day supply, \$20 for a 31- to 60-day supply, or \$30 for a 61- to 100-day supply after Deductible
Generic refills from our mail-order service	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply after Deductible
Brand-name items from a Plan Pharmacy	\$30 for up to a 30-day supply, \$60 for a 31- to 60-day supply, or \$90 for a 61- to 100-day supply after Deductible
Brand-name refills from our mail-order service.....	\$30 for up to a 30-day supply or \$60 for a 31- to 100-day supply after Deductible
Durable Medical Equipment	You Pay
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines.....	20% Coinsurance after Deductible
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	\$250 per admission after Deductible
Outpatient individual and group visits	\$30 per individual visit after Deductible \$15 per group visit after Deductible
Chemical Dependency Services	You Pay
Inpatient detoxification	\$250 per admission after Deductible
Outpatient individual visits	\$30 per visit after Deductible
Outpatient group visits	\$5 per visit after Deductible
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year).....	No charge after Deductible
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	\$250 per admission after Deductible
Hospice care	No charge after Deductible

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

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