



Customer Name: Redwood Empire Schools Insurance Group
Proposed Benefit Summary for Low Plan

Benefit Plan 2479
TYPE HSA; \$1250 DED;\$20 OUTP;
\$250 INPT; \$30/\$10 RX

Principal Benefits for Kaiser Permanente \$1,250 Deductible Plan with HSA Option
Effective: (10/01/2009—09/30/2010)

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 \$1,250 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)..... \$1,250 per calendar year
- For an entire Family of two or more Members..... \$2,500 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.....	\$20 per visit (Deductible doesn't apply)
Well-child visits (through age 23 months).....	\$10 per visit (Deductible doesn't apply)
Family planning visits.....	\$20 per visit after Deductible
Scheduled prenatal care visits.....	\$10 per visit (Deductible doesn't apply)
Eye refraction exams.....	\$20 per visit after Deductible
Hearing tests.....	\$20 per visit after Deductible
Primary and specialty care visits.....	\$20 per visit after Deductible
Urgent care visits.....	\$20 per visit after Deductible
Voluntary termination of pregnancy.....	\$20 per procedure after Deductible
Physical, occupational, and speech therapy.....	\$20 per visit after Deductible

Outpatient Services	You Pay
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Outpatient surgery and certain other outpatient procedures.....	\$150 per procedure after Deductible
Allergy injection visits.....	\$5 per visit after Deductible
Allergy testing visits.....	\$20 per visit after Deductible
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.....	\$20 per visit after Deductible
Group educational programs.....	No charge after Deductible (except the Deductible doesn't apply to tobacco-cessation programs)

Hospitalization Services	You Pay
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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
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Emergency Department visits.....	\$100 per visit after Deductible
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 **KAISER PERMANENTE**
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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 (DME)		You Pay
Most covered DME for home use in accord with our DME formulary guidelines .		20% Coinsurance after Deductible
Mental Health Services		You Pay
Inpatient psychiatric hospitalization (up to 30 days per calendar year)		\$250 per admission after Deductible
Outpatient visits:		
Up to a total of 20 individual and group visits per calendar year		\$20 per individual visit after Deductible \$10 per group visit after Deductible
Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year		\$10 per group visit after Deductible
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the EOC.		
Chemical Dependency Services		You Pay
Inpatient detoxification		\$250 per admission after Deductible
Outpatient individual visits		\$20 per visit after Deductible
Outpatient group visits		\$5 per visit after Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period).....		\$100 per admission 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).

For answers on benefit questions, verification of coverage, new member assistance, ID card replacement and to request a copy of your Evidence of Coverage, please contact our Member Services Call Center during the following business hours:

Member Services
Monday to Friday – 7:00AM to 7:00PM
Saturday & Sunday – 7:00AM to 3:00PM

English, Tagalog, and Vietnamese – 800.464.4000
Spanish – 800.788.0616
Chinese dialects – 800.757.7585

You may also visit us at www.kp.org