

Proposed Benefit Summary

100096 SAN BERNARDINO COMMUNITY COLLEGE DISTRICT – Keeping the current plan design as a part of the dual offering proposal.

Principal Benefits for Kaiser Permanente Traditional Plan (4/1/10—6/30/11)

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 Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, hospice care, Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services

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

For self-only enrollment (a Family of one Member).....	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year

Deductible or Lifetime Maximum None

Professional Services (Plan Provider office visits) You Pay

Routine preventive care:

Physical exams	\$20 per visit
Well-child visits (through age 23 months)	\$5 per visit
Family planning visits	\$20 per visit
Scheduled prenatal care visits and first postpartum visit	\$5 per visit
Eye exams for refraction	\$20 per visit
Hearing tests	\$20 per visit
Flexible sigmoidoscopies	\$20 per visit

Primary and specialty care visits	\$20 per visit
Urgent care visits.....	\$20 per visit
Physical, occupational, and speech therapy	\$20 per visit

Outpatient Services You Pay

Outpatient surgery and certain other outpatient procedures	\$20 per procedure
Allergy injection visits	\$5 per visit
Allergy testing visits	\$20 per visit
Most vaccines (immunizations)	No charge
X-rays and lab tests.....	No charge
Health education:	
Individual visits	\$20 per visit
Group educational programs.....	No charge

Hospitalization Services You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge
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Emergency Health Coverage You Pay

Emergency Department visits	\$100 per visit
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Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing)

Ambulance Services You Pay

Ambulance Services	\$100 per trip
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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
Generic refills from our mail-order service	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply
Brand-name items from a Plan Pharmacy	\$20 for up to a 30-day supply, \$40 for a 31- to 60-day supply, or \$60 for a 61- to 100-day supply
Brand-name refills from our mail-order service.....	\$20 for up to a 30-day supply or \$40 for a 31- to 100-day supply

continued

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
Mental Health Services	You Pay
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs.....	No charge
Outpatient individual and group visits.....	\$20 per individual visit \$10 per group visit
Chemical Dependency Services	You Pay
Inpatient detoxification.....	No charge
Outpatient individual visits.....	\$20 per visit
Outpatient group visits.....	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge
Other	You Pay
Eyewear purchased from plan optical sales offices every 24 months.....	Amount in excess of \$300 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
All covered Services related to infertility treatment	50% Coinsurance
Hospice care	No charge

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).

Proposed Benefit Summary

100096 SAN BERNARDINO COMMUNITY COLLEGE DISTRICT - DUALOPTION \$40 HI COPAY PLAN

Principal Benefits for High Copay HMO SCR (4/1/10—6/30/11)

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 Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, hospice care, Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services

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

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

Deductible or Lifetime Maximum None

Professional Services (Plan Provider office visits) You Pay

Routine preventive care:	
Physical exams	\$40 per visit
Well-child visits (through age 23 months)	\$10 per visit
Family planning visits	\$40 per visit
Scheduled prenatal care visits and first postpartum visit	\$10 per visit
Eye exams for refraction	\$40 per visit
Hearing tests	\$40 per visit
Flexible sigmoidoscopies	\$40 per visit
Primary and specialty care visits	\$40 per visit
Urgent care visits.....	\$40 per visit
Voluntary termination of pregnancy.....	\$40 per procedure
Physical, occupational, and speech therapy	\$40 per visit

Outpatient Services You Pay

Outpatient surgery and certain other outpatient procedures	\$250 per procedure
Allergy injection visits	\$5 per visit
Allergy testing visits	\$40 per visit
Most vaccines (immunizations)	No charge
X-rays and lab tests.....	\$10 per encounter
MRI, CT and PET	\$50 per procedure
Health education:	
Individual visits	\$40 per visit
Group educational programs.....	No charge

Hospitalization Services You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$500 per admission
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Emergency Health Coverage You Pay

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

Ambulance Services You Pay

Ambulance Services	\$150 per trip
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Prescription Drug Coverage You Pay

Most covered outpatient items in accord with our drug formulary guidelines:

Generic items from a Plan Pharmacy	\$15 for up to a 30-day supply, \$30 for a 31- to 60-day supply, or \$45 for a 61- to 100-day supply
Generic refills from our mail-order service	\$15 for up to a 30-day supply or \$30 for a 31- to 100-day supply

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Prescription Drug Coverage		You Pay
Brand-name items from a Plan Pharmacy		\$35 for up to a 30-day supply, \$70 for a 31- to 60-day supply, or \$105 for a 61- to 100-day supply
Brand-name refills from our mail-order service		\$35 for up to a 30-day supply or \$70 for a 31- to 100-day supply
Durable Medical Equipment		You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines		50% Coinsurance
Mental Health Services		You Pay
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs.....		\$500 per admission
Outpatient individual and group visits.....		\$40 per individual visit \$20 per group visit
Chemical Dependency Services		You Pay
Inpatient detoxification.....		\$500 per admission
Outpatient individual visits		\$40 per visit
Outpatient group visits.....		\$5 per visit
Home Health Services		You Pay
Home health care (up to 100 visits per calendar year)		No charge
Other		You Pay
Eyewear purchased from plan optical sales offices every 24 months.....		Amount in excess of \$300 Allowance
All covered Services related to infertility treatment		50% Coinsurance
Hospice care		No charge

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).