

Benefit Summary
SCHOOLS INSURANCE GROUP 602214B
Actives & Early Retirees

Principal Benefits for Kaiser Permanente \$2,000 Deductible Plan with HSA Option
(7/1/09—6/30/10)

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* 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 *Evidence of Coverage* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

Annual Out-of-Pocket Maximum for Certain Services	
For a Subscriber (self-only enrollment)	\$3,000 per calendar year
For an entire Family Unit of two or more Members	\$6,000 per calendar year
All Deductible payments, Copayments, and Coinsurance for all Services count toward this maximum.	
Deductible for all Services except certain preventive Services as specified below	
For a Subscriber (self-only enrollment)	\$2,000 per calendar year
For an entire Family Unit 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
Coordination of Benefits	Included
Professional Services (Plan Provider office visits)	You Pay
Primary and specialty care visits (includes routine and Urgent Care appointments)	\$30 per visit after Deductible
Routine preventive physical exams	\$30 per visit (Deductible doesn't apply)
Well-child preventive care visits (0–23 months)	\$10 per visit (Deductible doesn't apply)
Family planning visits	\$30 per visit after Deductible
Scheduled prenatal care	\$10 per visit (Deductible doesn't apply)
Voluntary termination of pregnancy	\$30 per procedure after Deductible
Eye exams	\$30 per visit after Deductible
Hearing tests	\$30 per visit after Deductible
Physical, occupational, and speech therapy visits	\$30 per visit after Deductible
Outpatient Services	You Pay
Outpatient surgery	\$150 per procedure after Deductible
Allergy injection visits	\$5 per visit after Deductible
Allergy testing visits	\$30 per visit after Deductible
Vaccines (immunizations)	No charge (Deductible doesn't apply)
Most X-rays and lab tests	\$10 per encounter (except that MRI, CT, and PET are \$50 per procedure) after Deductible
Preventive screenings described in the <i>Evidence of Coverage</i>	\$10 per encounter (Deductible doesn't apply)
Health education	\$30 per individual visit after Deductible No charge for group visits after Deductible (except the Deductible doesn't apply to tobacco cessation classes)
Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$250 per admission after Deductible
Emergency Health Coverage	You Pay
Emergency Department visits	\$100 per visit after Deductible

continued

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 from Plan Pharmacies:	
Generic items from a Plan Pharmacy	\$10 for up to a 30 day supply, \$20 for a 31–60 day supply, or \$30 for a 61–100 day supply after Deductible
Refills from our mail order program	\$20 for up to a 100 day supply after Deductible
Brand name items from a Plan Pharmacy	\$30 for up to a 30 day supply, \$60 for a 31–60 day supply, or \$90 for a 61–100 day supply after Deductible
Refills from our mail order program	\$60 for up to a 100 day supply after Deductible
Durable Medical Equipment	You Pay
Most covered durable medical equipment for home use in accord with our DME formulary	20% Coinsurance after Deductible
Mental Health Services	You Pay
Inpatient psychiatric care (up to 30 days per calendar year)	\$250 per admission after Deductible
Outpatient visits:	
Up to a total of 20 individual and group therapy visits per calendar year	\$30 per individual therapy visit after Deductible \$15 per group therapy visit after Deductible
Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year	\$15 per group therapy 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 <i>Evidence of Coverage</i> .	
Chemical Dependency Services	You Pay
Inpatient detoxification	\$250 per admission after Deductible
Outpatient individual therapy visits	\$30 per visit after Deductible
Outpatient group therapy 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 two-hour 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, Deductibles, exclusions, or limitations, and it does not list all benefits, Copayments, and Coinsurance. For a complete explanation, please refer to the *Evidence of Coverage*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).