

Benefit Summary
SCHOOLS INSURANCE GROUP
Active Employees & Early Retirees
Principal Benefits for Kaiser Permanente Traditional Plan
(7/1/06—6/30/07)

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 Service Area, except where specifically noted to the contrary for authorized referrals, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services described in the *Evidence of Coverage*

Annual Out-of-Pocket Maximum	
For one Member	\$1,500 per calendar year
For an entire Family Unit	\$3,000 per calendar year
Deductible or Lifetime Maximum	
	None
Professional Services (Plan Provider office visits)	
You Pay	
Primary and specialty care visits (includes routine and urgent care appointments)	\$5 - \$20 per visit (depending on plan)
Routine physical exams	\$5 - \$20 per visit (depending on plan)
Well-child preventive care visits to age 2	\$5 - \$15 per visit (depending on plan)
Family planning visits	\$5 - \$20 per visit (depending on plan)
Scheduled prenatal care and first postpartum visit	\$5 - \$15 per visit (depending on plan)
Eye exams	\$5 - \$20 per visit (depending on plan)
Hearing tests	\$5 - \$20 per visit (depending on plan)
Physical, occupational, and speech therapy visits	\$5 - \$20 per visit (depending on plan)
Outpatient Services	
You Pay	
Outpatient surgery	\$5 - \$20 per visit (depending on plan)
Allergy injection visits	\$3 per visit
Allergy testing visits	\$5 - \$20 per visit (depending on plan)
Immunizations	No charge
X-rays and lab tests	No charge
Health education	\$5 - \$20 per visit (depending on plan)
	No charge for group visits
Hospitalization Services	
You Pay	
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge
Emergency Health Coverage	
You Pay	
Emergency Department visits	\$50 per visit (waived if you are held for observation in a hospital unit outside the Emergency Department or if admitted directly to the hospital as an inpatient)
Ambulance Services	
You Pay	
Ambulance Services	\$50 per trip
Prescription Drug Coverage	
You Pay	
Most covered outpatient items in accord with our drug formulary when obtained at Plan Pharmacies:	
Generic items	\$5 - \$20 (depending on plan) for up to a 100-day supply
Brand name items	\$5, \$10 or \$25 (depending on plan) for up to a 100-day supply
Durable Medical Equipment	
You Pay	
Most covered durable medical equipment for home use in accord with our DME formulary	20% Coinsurance
Mental Health Services	
You Pay	
Inpatient psychiatric care (up to 45 days per calendar year)	No charge
Outpatient visits:	
Up to a total of 20 individual and/or group therapy visits per calendar year	\$5 - \$20 (depending on plan) per individual therapy visit \$2 - \$10 (depending on plan) per group therapy visit
Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year	\$2 - \$10 (depending on plan) per group therapy visit

Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Outpatient individual therapy visits	\$5 - \$20 (depending on plan)
Outpatient group therapy visits	\$2 - \$5 (depending on plan) per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission
Home Health Services	You Pay
Home health care	No charge
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

Optional Benefits (check with your district if covered)	You Pay
Chiropractic Coverage	\$10 per visit up to 30 visits
Eyewear purchased from Plan optical sales offices every 24 months	\$175 Allowance

This is a brief summary of the most frequently asked about benefits and their Copayments and Coinsurance. This chart does not describe benefits and it does not list all benefits, Copayments, and Coinsurance. Please refer to the *Evidence of Coverage* to learn about coverage (including exclusions and limitations) and other benefits, Copayments, and Coinsurance that are not included in this summary. Note: We cover benefits in accord with applicable law (for example, diabetes supplies).

Kaiser Plan	Co-Pay / Rx Co-Pay
9565	\$5 / \$5
35876	\$10 / \$10 (generic) & \$25 (brand)