

# Summary of medical benefits

01/01/2007 through 12/31/2007

SB-1500 Oregon

<b>Annual individual deductible</b>	\$1,500 <sup>1</sup>
<b>Annual family deductible</b>	\$3,000 <sup>2</sup>
<b>Annual individual out-of-pocket maximum</b>	\$5,000 <sup>1</sup>
<b>Annual family out-of-pocket maximum</b>	\$10,000 <sup>2</sup>
<b>Lifetime benefit maximum</b>	\$2,000,000
<b>Benefit</b> (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	<b>You pay</b>
<b>Office visits for</b>	
Preventive care	See primary care; no charge for age 0-2
Primary care, including urgent care	20% <sup>3</sup>
Specialty care	20% <sup>3</sup>
Prenatal care	20%
Routine eye exam	20% <sup>3</sup>
Allergy shots and other injections	\$5 <sup>3</sup>
Routine immunizations	No charge
Rehabilitative therapies	See specialty care <sup>3</sup>
Outpatient surgery	20% <sup>3</sup>
<b>X-rays, imaging, laboratory, and special diagnostic procedures</b>	20% <sup>3</sup>
<b>Outpatient prescription drugs</b>	Applies if optional drug plan purchased. Kaiser Permanente formulary applies. <sup>4</sup>
<b>Hospital inpatient care</b>	20% <sup>5</sup>
<b>Hospital maternity care for mother and newborn</b>	Same as hospital inpatient care
<b>Emergency department visit</b>	20% <sup>6</sup>
<b>Ambulance services</b>	20% <sup>3</sup>
<b>Mental health services</b>	
Inpatient psychiatric care.	Same as hospital inpatient care
Residential/day treatment.	Residential treatment: Same as inpatient for up to 45 days per year Day treatment: Primary care copay per day
Outpatient treatment.	Primary care copayment
<b>Chemical dependency services</b>	
Inpatient care	Same as hospital inpatient care
Residential/day treatment	Same as hospital inpatient care
Outpatient treatment	Primary care copayment

<b>Benefit</b> (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	<b>You pay</b>
<b>Skilled nursing facility care</b>	10% for up to 100 days per year <sup>3</sup>
<b>Home health care</b>	20% <sup>7</sup>
<b>Infertility services</b>	50% for diagnosis and treatment <sup>3</sup>
<b>Durable medical equipment</b>	20% <sup>3</sup>
<b>Alternative care</b>	Applies if optional alternative care plan purchased. <sup>8</sup>
<b>Prescription eyeglasses and contact lenses</b>	Applies if optional vision plan purchased.

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**Questions? Call Membership Services** (M-F, 8 am-6 pm)

Portland area...503-813-2000. All other areas...1-800-813-2000. TTY...1-800-735-2900

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This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on your benefit coverage, claims review, and adjudication procedures, please see A Guide to Your Benefits (or EOC) or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.

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Footnotes: <sup>1</sup>Per calendar year. <sup>2</sup>Per calendar year. Maximum can be met by one family member. <sup>3</sup>After deductible. <sup>4</sup>We cover nonformulary drugs only when you meet exception criteria. <sup>5</sup>After deductible. Includes room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs. <sup>6</sup>After deductible. Coinsurance not waived if admitted. <sup>7</sup>After deductible for up to 130 visits per year. <sup>8</sup>Self referral to network alternative care providers.