

# Summary of medical benefits

2009

AOI-PREFERRED PLUS W/CHIRO	05715-043
<b>Annual individual deductible</b>	None
<b>Annual family deductible</b>	None
<b>Annual individual out-of-pocket maximum</b>	\$750 <sup>1</sup>
<b>Annual family out-of-pocket maximum</b>	\$1,500 <sup>1</sup>
<b>Lifetime benefit maximum</b>	None
<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	\$10
Primary care, including urgent care	\$10
Specialty care	\$10
Prenatal care	\$10
Routine eye exam	\$10
Allergy shots and other injections	\$5
Routine immunizations	No charge
Rehabilitative therapies	See specialty care <sup>2</sup>
Outpatient surgery	\$250 <sup>3</sup>
<b>X-rays, imaging, laboratory, and special diagnostic procedures</b>	\$10 per visit
<b>Outpatient prescription drugs</b>	\$5 generic/\$15 brand. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two copayments. <sup>4</sup>
<b>Hospital inpatient care</b>	\$100 per admission <sup>5</sup>
<b>Hospital maternity care for mother and newborn</b>	Same as hospital inpatient care
<b>Emergency department visit</b>	\$50 <sup>6</sup>
<b>Ambulance services</b>	\$50
<b>Mental health services</b>	
Inpatient psychiatric care	Same as hospital inpatient care
Residential/day treatment	Residential: Same as inpatient for up to 45 days per year / Day treatment: Same as primary care per day
Outpatient treatment	Same as primary care
<b>Chemical dependency services</b>	
Inpatient care	Same as hospital inpatient care

<b>Benefit</b> (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	<b>You pay</b>
Residential/day treatment	Residential: Same as inpatient / Day treatment: Same as primary care per day
Outpatient treatment	Same as primary care
<b>Skilled nursing facility care</b>	See hospital inpatient care; you are covered for up to 60 days per year
<b>Home health care</b>	\$0 for up to 130 visits per year
<b>Infertility services</b>	50% for diagnosis and treatment
<b>Durable medical equipment</b>	20%
<b>Chiropractic care</b>	\$15/visit for up to 15 visits per year. <sup>7</sup>
<b>Prescription eyeglasses and contact lenses</b>	Not covered
<b>Hearing aids</b>	Not covered
<b>Dependent age limits:</b> Your group plan covers enrolled dependents to age 23.	

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

Portland area...503-813-2000. All other areas...1-800-813-2000. TTY...1-800-735-2900. Language Interpretation Services, all areas...1-800-324-8010

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 your evidence of coverage (or EOC) or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.

Footnotes: <sup>1</sup>Per calendar year. <sup>2</sup>Limited to 20 visits per therapy per year. <sup>3</sup>Includes endoscopy procedures. <sup>4</sup>Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria. <sup>5</sup>Includes room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs. <sup>6</sup>Copay waived if admitted. <sup>7</sup>Self referral to network providers.