

Summary of medical benefits

2009

AOI STANDARD W/O VISION+CHIRO	05715-010
Annual individual deductible	None
Annual family deductible	None
Annual individual out-of-pocket maximum	\$1,500 ¹
Annual family out-of-pocket maximum	\$3,000 ¹
Lifetime benefit maximum	None
Benefit (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	You pay
Office visits for	
Preventive care	\$20
Primary care, including urgent care	\$20
Specialty care	\$20
Prenatal care	\$20
Routine eye exam	\$20
Allergy shots and other injections	\$5
Routine immunizations	No charge
Rehabilitative therapies	See specialty care ²
Outpatient surgery	\$100 ³
X-rays, imaging, laboratory, and special diagnostic procedures	\$0 per visit
Outpatient prescription drugs	\$10 generic/\$20 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. ⁴
Hospital inpatient care	\$100 per day, up to \$500 per admission ⁵
Hospital maternity care for mother and newborn	Same as hospital inpatient care
Emergency department visit	\$50 ⁶
Ambulance services	\$50
Mental health services	
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
Chemical dependency services	
Inpatient care	Same as hospital inpatient care

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

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