

# Summary of medical benefits

# 2008

WFOA - ACTIVES	04565-001
<b>Annual individual deductible</b>	None
<b>Annual family deductible</b>	None
<b>Annual individual out-of-pocket maximum</b>	\$600 <sup>1</sup>
<b>Annual family out-of-pocket maximum</b>	\$1,200 <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	See primary care; no charge for age 0-2
Primary care, including urgent care	\$5
Specialty care	\$5
Prenatal care	No charge
Routine eye exam	\$5
Allergy shots and other injections	\$5
Routine immunizations	No charge
Rehabilitative therapies	See specialty care <sup>2</sup>
Outpatient surgery	See specialty care <sup>3</sup>
<b>X-rays, imaging, laboratory, and special diagnostic procedures</b>	No charge
<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>	No charge <sup>5</sup>
<b>Hospital maternity care for mother and newborn</b>	Same as hospital inpatient care
<b>Emergency department visit</b>	\$75
<b>Ambulance services</b>	\$75
<b>Mental health services</b>	
Inpatient psychiatric care.	2-yr benefit period ends 12/31/07. Same as hospital inpatient care for up to 16 days.
Residential/day treatment.	\$50/day up to \$250/admission for up to 26 days.
Outpatient therapy with mental health professionals.	Same as primary care for up to 40 visits.
<b>Chemical dependency services</b>	
Inpatient medical treatment	2-yr benefit period ends 12/31/09. <sup>6</sup> No charge

<b>Benefit</b> (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	<b>You pay</b>
Residential/day treatment	No charge
Outpatient treatment	Same as primary care
<b>Skilled nursing facility care</b>	No charge for up to 100 days per year
<b>Home health care</b>	No charge <sup>7</sup>
<b>Infertility services</b>	Same as any other medical condition
<b>Durable medical equipment</b>	20%
<b>Spinal and extremity manipulation therapy and other alternative care</b>	\$5 per visit for spinal and extremity manipulation therapy, massage therapy, acupuncture or naturopathy. \$1,000 benefit maximum per year for massage, acupuncture, and naturopathy. <sup>8</sup>
<b>Prescription eyeglasses and contact lenses</b>	Balance after \$150 credit is applied. Your benefit renews every 24 months. <sup>9</sup>

**Dependent age limits:** Your group plan covers enrolled dependents to age 25.

### 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>Total benefit maximum: We pay up to \$14,000 for 2008/\$14,500 for 2009. <sup>7</sup>For up to 130 visits per year. <sup>8</sup>Care must be provided by network providers. Up to 12 self-referred spinal manipulation therapy visits per year. Additional visits provided if treatment extension is approved by designated network. <sup>9</sup>Professional fees for cosmetic contact lenses not covered.