



# Summary of medical benefits

10/01/2009 through 09/30/2010

NATA - Deductible \$1000	14200
<b>Annual individual deductible</b>	\$1,000 <sup>1</sup>
<b>Annual family deductible</b>	\$3,000 <sup>1</sup>
<b>Annual individual out-of-pocket maximum</b>	\$3,000 <sup>2</sup>
<b>Annual family out-of-pocket maximum</b>	\$9,000 <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; \$0 for age 0-2
Primary care.	\$25
Specialty care	\$35
Prenatal care	\$25
Routine eye exam	\$25
Allergy shots and other injections	\$10
Routine immunizations	\$0
Rehabilitative therapies	See specialty care <sup>3</sup>
Outpatient surgery	20% <sup>4</sup>
<b>X-rays, imaging, laboratory, and special diagnostic procedures</b>	\$10 per visit
<b>Outpatient prescription drugs</b>	\$20/prescription. 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>5</sup>
<b>Hospital inpatient care</b>	20% <sup>6</sup>
<b>Hospital maternity care for mother and newborn</b>	Same as hospital inpatient care
<b>Emergency department visit</b>	20% <sup>7</sup>
<b>Ambulance services</b>	20%
<b>Mental health services</b>	
Inpatient 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>	20% for up to 100 days per year <sup>8</sup>
<b>Home health care</b>	20% for up to 130 visits per year <sup>8</sup>
<b>Infertility services</b>	50% for diagnosis and treatment <sup>8</sup>
<b>Durable medical equipment</b>	20%
<b>Prescription eyeglasses and contact lenses</b>	Balance after \$150 credit is applied. <sup>9</sup>

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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. 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>Per calendar year. Excludes amounts applied to deductible and services not subject to deductible. <sup>3</sup>After deductible for up to 20 visits per therapy per year. <sup>4</sup>After deductible. Includes endoscopy procedures. <sup>5</sup>Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria. <sup>6</sup>After deductible. Includes room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs. <sup>7</sup>After deductible. Coinsurance not waived if admitted. <sup>8</sup>After deductible. <sup>9</sup>Benefit renews every 24 months. Professional fees for cosmetic contact lenses not covered. If the full credit is not used in the first visit, the balance is forfeited.