



Summary of medical benefits

10/01/2008 through 09/30/2009

NATA Plan B with Vision	14200
Annual individual deductible	\$250 ¹
Annual family deductible	\$750 ¹
Annual individual out-of-pocket maximum	\$2,000 ²
Annual family out-of-pocket maximum	\$6,000 ²
Lifetime benefit maximum	\$2,000,000
Benefit (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	You pay
Office visits for	
Preventive care	See primary care; \$0 for age 0-2
Primary care, including urgent care	\$15
Specialty care	\$25
Prenatal care	\$15
Routine eye exam	\$15
Allergy shots and other injections	\$5
Routine immunizations	\$0
Rehabilitative therapies	See specialty care ³
Outpatient surgery	20% ⁴
X-rays, imaging, laboratory, and special diagnostic procedures	\$10 per visit
Outpatient prescription drugs	\$15 generic/\$30 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. ⁵
Hospital inpatient care	20% ⁶
Hospital maternity care for mother and newborn	Same as hospital inpatient care
Emergency department visit	20% ⁷
Ambulance services	20%
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
Residential/day treatment	Same as hospital inpatient care

Benefit (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	You pay
Outpatient treatment	Primary care copayment
Skilled nursing facility care	20% for up to 100 days per year ⁸
Home health care	20% for up to 130 visits per year ⁸
Infertility services	50% for diagnosis and treatment ⁸
Durable medical equipment	20%
Alternative care	\$15/chiropractor, acupuncture, or naturopath visit. \$25/massage therapy visit. ⁹
Prescription eyeglasses and contact lenses	Balance after \$150 credit is applied. Your benefit renews every 24 months. ¹⁰
Hearing aids	Not covered
Dependent age limits: Your group plan covers enrolled dependents to age 23.	

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: ¹Per calendar year. Deductible amounts do not apply to out-of-pocket maximum. ²Per calendar year. Excludes amounts applied to deductible and services not subject to deductible. ³After deductible for up to 20 visits per therapy per year for PT/OT/Speech. ⁴After deductible. Includes endoscopy procedures. ⁵Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria. ⁶After deductible. Includes room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs. ⁷After deductible. Coinsurance not waived if admitted. ⁸After deductible. ⁹Self referral to network providers. \$1,000 benefit maximum per year. Massage therapy limited to 12 visits per year. ¹⁰Professional fees for cosmetic contact lenses not covered. If the full credit is not used in the first visit, the balance is forfeited.