

SUMMARY OF MEDICAL BENEFITS

10/01/2011 through 09/30/2012
MEDICAL PLAN 1



Deductible	You Pay
For one member	None
For an entire family	None
Out-Of-Pocket Maximum	You Pay
For one member	\$1,200 per plan year
For an entire family	\$2,400 per plan year
Lifetime Benefit Maximum	Unlimited
Preventive Care Services	You Pay
Routine preventive physical exam (includes adult, well baby, and well child)	\$0
Scheduled prenatal care and first postpartum visit	\$0
Immunizations	\$0
Preventive tests	\$0
Outpatient Services	You Pay
Primary care visit (includes routine OB/GYN visits and medical office visits, routine hearing exams, diabetic outpatient self-management training and education, including medical nutrition therapy)	\$15
Specialty care visit (includes TMJ therapy and diabetic outpatient self-management training and education, including medical nutrition therapy; see primary care for OB/GYN visits)	\$25
Routine eye exam	\$5
Injections provided in nurse treatment area	\$10
Emergency Department visit (waived if admitted)	\$100
Urgent care	\$35
Outpatient surgery visit	\$75, \$0 for colonoscopy
Outpatient respiratory therapy	\$25
Outpatient Prescription Drugs (\$1,100 Out-Of-Pocket Maximum Per Individual Per Year)	You Pay
Generic (up to 30-day supply)	\$5
Preferred brand (up to 30-day supply)	\$25
Non-preferred brand (up to 30-day supply)	\$25 if exception criteria is met
Mail order (up to 90-day supply)	90-day supply of maintenance medications for two copayments
Hospital Inpatient Services	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	\$100 per day, up to \$500 per admission
Self-Referred Alternative Care Services (\$2,000 Combined Annual Benefit Maximum)	You Pay
Chiropractic, naturopathy, and acupuncture	\$15
Ambulance Services	You Pay
Per transport	\$75
Chemical Dependency Services	You Pay
Outpatient services	\$15
Inpatient hospital services	\$100 per day, up to \$500 per admission
Residential services	\$100 per day, up to \$500 per admission
Day treatment services	\$15 per day
Outpatient Durable Medical Equipment, External Prosthetics, and Orthotics	You Pay
Outpatient durable medical equipment, external prosthetics, and orthotics	20% coinsurance

Hearing Services	You Pay
One hearing aid per ear for a combined allowance of up to \$4,000 every 48 months*	10% coinsurance
Home Health Services	You Pay
Home health (up to 130 visits per plan year for part-time or intermittent home health services)	\$0
Mental Health Services	You Pay
Outpatient services	\$15
Intensive outpatient services	\$15 per day
Inpatient hospital services	\$100 per day, up to \$500 per admission
Residential services	\$100 per day, up to \$500 per admission
Outpatient Laboratory, X-rays, Imaging, and Special Diagnostic Procedures	You Pay
Laboratory, X-rays, imaging, and special diagnostic procedures visit	\$15
Rehabilitative Therapy Services	You Pay
Outpatient physical, speech, and occupational therapies (limited to 20 visits per therapy per plan year)	\$25
Multidisciplinary rehabilitation (limited to a combined total of 60 days per condition per plan year for inpatient and outpatient rehabilitation)	
Inpatient multidisciplinary rehabilitation	\$100 per day, up to \$500 per admission
Outpatient multidisciplinary rehabilitation	\$25
Skilled Nursing Facility Services	You Pay
Inpatient skilled nursing services (100-day maximum per plan year)	\$0
Prescription Eyeglasses and Contact Lenses (Optional Benefit Rider)	You Pay
Lenses single vision	No charge up to \$58.50
Lenses bifocal and lenticular	No charge up to \$86
Lenses trifocal	No charge up to \$109
Conventional and disposable contact lenses	No charge up to \$192.50
Lens frequency	12 months
Frames	No charge up to \$75
Frames frequency	12 months child (under 18) 24 months adult

Questions? Call Membership Services (Monday through Friday, 8 a.m.–6 p.m.)

All areas...1-866-223-2375 toll free. 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 of your benefit coverage, claims review, and adjudication procedures, please see your evidence of coverage (EOC) or call Membership Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

*For dependent children under 26, the allowance is adjusted each January 1 based on the Consumer Price Index.