KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of medical benefits

NATA 14200
Oregon Deductible Plan 2L12
October 1, 2012 through September 30, 2013

Deductible	
For one Member	$500 per Calendar Year
For an entire Family	$1,500 per Calendar Year
Out-Of-Pocket Maximum (Not all services apply to the maximum; refer to your Evidence of Coverage for clarification. Deductible amounts and Services not subject to the Deductible do not count toward your Out-of-Pocket Maximum.)	
For one Member	$2,500 per Calendar Year
For an entire Family	$7,500 per Calendar Year
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$20
Specialty care visit	$30
Routine eye exam	$20
Allergy shots and other injections	$10
Urgent Care visit	$40
Emergency department visit	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Physician-referred acupuncture (limited to 12 visits per Calendar Year)	$30
Inpatient Hospital Services	20% Coinsurance after Deductible
Ambulance Services (per transport)	20% Coinsurance
Chemical Dependency Services	
Outpatient Services	$20
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	
Outpatient Services	$20
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices	20% Coinsurance
Hearing Aids for Children (up to $4,211 every 48 months, per Member under age 18 and any child Dependent)	20% Coinsurance
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	$20 per department visit
Outpatient Rehabilitative Therapy Services (up to 20 visits per therapy per Calendar Year)	
Physical, Speech, and Occupational therapies	$30 after Deductible
All other therapies	$30 after Deductible
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Optional Benefits	

Alternative Care (self-referred)	$20 per visit for chiropractic, naturopathic and acupuncture visits. $25 per massage therapy visits (up to 12 visits per Calendar Year). $1,000 benefit maximum for all Services combined.
Hearing Aids (for Members age 18 and over)	Not covered
Outpatient Prescription Drugs, Supplies, and Supplements	$20 generic/$40 brand up to 30-day supply; up to 90-day supply of maintenance drugs for two Copayments when you use mail delivery.
Vision Hardware Optical Services	Not covered
Travel Services	Not covered

Exclusions and Limitations

The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the Evidence of Coverage.

Acupuncture. Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) your employer Group has purchased the Alternative Care (self-referred Acupuncture Services) rider.; **Certain exams and Services**; **Chiropractic Services received without a referral by Kaiser Permanente.** Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care Services or Chiropractic Services (self-referred Chiropractic Care) rider has been purchased.; **Cosmetic Services**; **Custodial Services**; **Dental Services.** Except when Medically Necessary for Members who have a medical condition that would place undue risk if performed in a dental office. The procedure must be approved.; **Designated blood donations**; **Detained or confined members**; **Employer responsibility**; **Experimental or investigational Services**; **Eye surgery**; **Family Services.** Services provided by a member of your immediate family.; **Genetic testing**; **Government agency responsibility**; **Hearing aids.** Unless the Hearing Aid rider has been purchased.; **Hypnotherapy**; **Intermediate Services**; **Massage therapy Services.** Limited to when: (a) a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care (Massage Therapy) benefit rider has been purchased.; **Naturopathy Services.** Limited to when: (a) referral for Services in accord with Medical Group criteria; or (b) Alternative Care (Naturopathy Services) rider has been purchased.; **Non-Medically Necessary Services**; **Nonreusable medical supplies**; **Outpatient Prescription Drugs.** Unless the Outpatient Prescription Drug rider has been purchased. Kaiser Permanente formulary applies. We cover non-formulary drugs only when you meet exception criteria unless specifically covered by your prescription drug plan.; **Services related to a non-covered Service**; **Sexual reassignment surgery**; **Supportive care and other Services**; **Travel and lodging.** Limited to: (a) Medically Necessary "Ambulance Services" in this *Summary*, and (b) certain expenses that we preauthorize.; **Travel Services.** All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless the Travel Services rider has been purchased.; **Vision hardware optical Services**. Unless the Vision Hardware Optical Services rider has been purchased.; **Vision therapy and orthoptics or eye exercises**; **Professional Services for fitting and follow-up care for contact lenses**; **Low-vision aids**.

Questions? Call Membership Services (M-F, 8 am-6 pm) or visit **kp.org**
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 (EOC) or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.