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

Portland Va Research Foundation 9203-011, 012
Oregon Added Choice Plan
June 1, 2011 through May 31, 2012

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers
Deductible			
For one Member per Calendar Year	$0	$300	$300
For an entire Family per Calendar Year	$0	$900	$900
Out-of-Pocket Maximum (Deductible amounts do not apply to your Out-of-Pocket Maximum. In Tier 2 and Tier 3, Copayments also do not count toward your Out-of-Pocket Maximum.)			
For one Member per Calendar Year	$1,000	$1,500	$4,500
For an entire Family per Calendar Year	$2,000	$4,500	$13,500
Outpatient Services	**You Pay***		
Routine preventive physical exam (includes adult, well baby, and well child)	$0	$20	30%
Primary care visit	$10	$20	30%
Specialty care visit	$10	$20	30%
Prenatal care visit	$0	$20	30%
Routine eye exam	$10	$20	30%
Allergy shots and other injections	$10	$20	30%
Immunizations	$0	$0	$0
Urgent Care visits	$30	$40	30%
Emergency department visit	$100 (Copayment waived if admitted)		
Outpatient surgery	$50	10% of Charges	30%
Inpatient Hospital Services	$200 per admission	10% of Charges	30%
Ambulance Services (per emergency transport)	$100		
Chemical Dependency Services			
Outpatient Services	$10	$20	30%
Inpatient hospital & residential Services	$200 per admission	10% of Charges	30%
Mental Health Services			
Outpatient Services	$10 per visit	$20	30%
Inpatient hospital & residential Services	$200 per admission	10% of Charges	30%
Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics	20% Coinsurance	30% of Charges	40%
Hearing Aids for Children (up to $4,080 every 48 months, per Member under age 18 and any child Dependent)	20% Coinsurance	30% of Charges	40%
Outpatient Laboratory, X-rays, Imaging, and Special Diagnostic Procedures	$0 per department visit	$10 per department visit	30%
Outpatient Rehabilitative Therapy Services (up to 20 visits per therapy per Calendar Year) (All tiers combined)	$10	$20	30%
Skilled Nursing Facility Services (up to 100 days per Calendar Year) (All tiers combined)	$0	10% of Charges	30%
Optional Benefits			

Alternative Care	$10 per visit for chiropractic, naturopathic and acupuncture visits. $25 Copayment per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.	$10 per visit for chiropractic, naturopathic and acupuncture visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Hearing Aids (All tiers combined)	Not covered	Not covered
Outpatient prescription drugs, supplies, and supplements	$15 generic/$30 brand up to 30-day supply; up to a 90-day supply of maintenance drugs for two Copayments.	$20/prescription for generic drugs $40/prescription for preferred brand drugs, and $60/prescription for non-preferred brand drugs at participating pharmacies.
Vision hardware optical services	Balance after $150 allowance every 24 months	Balance after $150 credit every 24 months

***Note:** All Tier 2 and Tier 3 covered Services are subject to the Deductible, except office visits with a Copayment (a defined dollar amount) and certain other Services as noted. After you meet your Deductible, you pay the amount listed in this summary.
For Tier 3, Coinsurance is of Usual and Customary Fees (U&C), plus any excess over U&C.

Exclusions, Limitations, and Reductions

Exclusions that Apply to All Three Tiers
The Services listed below are excluded from coverage under this *Summary* for all three tiers. These exclusions apply to all Services that would otherwise be covered under this *Summary*. Additional exclusions that apply only to Tier 2 or Tier 3 are listed under "Exclusions that Apply Only to Tier 2 and Tier 3" in the "Exclusions, Limitations, and Reductions" section. Additional exclusions that apply only to a particular Service are listed in the description of that Service in this *Summary*.

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. For Tier 1 only, 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 reassigment 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.; **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.** Unless the Vision Hardware Optical Services rider has been purchased; **Low-vision aids**.

Exclusions that Apply Only to Tier 2 and Tier 3
The Services listed below are excluded from coverage under this *Summary* for Tier 2 and Tier 3. These exclusions apply to all Services that would otherwise be covered under this *Summary* Additional exclusions that apply only to a particular Service are listed in the description of that Service in this *Summary*.
Telehealth and Telemedicine; Transplants and transplant Services.

Limitations that Apply to Tier 1 and Tier 2
The Services listed below have coverage limitations under this *Summary* for Tier 1 and Tier 2. These limitations apply to all Services that would otherwise be covered under this *Summary*. Additional limitations that apply only to a particular Service are listed in the description of that Service in this *Summary*.

Unusual Circumstances
In the event of unusual circumstances that delay or render impractical the provision of Services under this *Summary*, neither we nor any Select Provider, Select Facility, PPO Provider, or PPO Facility shall have any liability or obligation because of a delay or failure to provide these Services.

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 (EOC) or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.