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

Free Geek 11367-303, 306
Oregon Added Choice Plan Map2
December 1, 2012 through November 30, 2013

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers
Deductible			
For one Member per Calendar Year	$0	$1,000	$1,000
For an entire Family per Calendar Year	$0	$3,000	$3,000
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. The amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in one Tier count toward the Out-of-Pocket Maximum in each of the other two Tiers.)			
For one Member per Calendar Year	$2,000	$3,000	$4,000
For an entire Family per Calendar Year	$6,000	$9,000	$12,000
Preventive Care Services	**You Pay***		
Routine preventive physical exam (includes adult, well baby, and well child)	$0	$30	40% Coinsurance after Deductible
Scheduled prenatal care and first postpartum visit	$0	$30	40% Coinsurance after Deductible
Immunizations	$0	$0	$0
Preventive tests	$0	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Services			
Primary care visit	$20	$30	40% Coinsurance after Deductible
Specialty care visit	$20	$30	40% Coinsurance after Deductible
Urgent care visit	$40	$50	40% Coinsurance after Deductible
Emergency department visit	$150 (Waived if admitted)		
Outpatient surgery visit	$150	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$20	$30	40% Coinsurance after Deductible
Laboratory, X-rays, imaging, and special diagnostic procedures	$20 per department visit	30% Coinsurance after Deductible	40% Coinsurance after Deductible
CT, MRI, PET scans	$100	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Administered medications (all outpatient settings)	20% Coinsurance	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Routine eye exam	$20	$30	40% Coinsurance after Deductible
Injection visit provided in nurse treatment area	$10	$30	40% Coinsurance after Deductible

Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$20	$30	40% Coinsurance after Deductible
Physician-referred acupuncture (limited to 12 visits per Calendar Year)	$20	Not covered	Not covered
Inpatient Hospital Services	$300 per day up to $1,500 per admission	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulance Services (per emergency transport)	$150		
Hearing Aids for Children (up to $4,211 every 48 months, per Member under age 18 and any child Dependent)	20% Coinsurance	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility Services (up to 100 days per Calendar Year) (All tiers combined)	20% Coinsurance	30% Coinsurance after Deductible	40% 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.	$20 per visit for chiropractic, naturopathic and acupuncture visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,000 benefit maximum for all Services combined.	
Outpatient prescription drugs	$15 generic/$30 brand/$50 approved nonformulary brand up to 30-day supply; up to 90-day supply of maintenance drugs for two Copayments when you use mail delivery.	$20/prescription for generic drugs $40/prescription for preferred brand drugs, and $60/prescription for non-preferred brand drugs at participating pharmacies.	
Vision hardware and optical services	Balance after $150 allowance every 24 months		
Chemical Dependency Services			
Outpatient Services	$20	$30	40% Coinsurance after Deductible
Inpatient hospital & residential Services	$300 per day up to $1,500 per admission	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health Services			
Outpatient Services	$20 per visit	$30	40% Coinsurance after Deductible
Inpatient hospital & residential Services	$300 per day up to $1,500 per admission	30% Coinsurance after Deductible	40% Coinsurance after Deductible

***Note:** In Tier 1 and Tier 2, Coinsurance is a percentage of Charges. In Tier 3, Coinsurance is a percentage of the Allowed Amount; you also pay any excess over the Allowed Amount

Exclusions and Limitations that Apply to All Three Tiers

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 Care**; **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 is subject to Utilization Review.; **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**.; **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. At a MedImpact Pharmacy, if a generic equivalent is available and you or your prescribing provider choose brand, you pay the difference between the pharmacy's retail prices for brand and generic in addition to the preferred or non-preferred brand Copayment or Coinsurance.; **Services performed by unlicensed people; Services related to a non-covered Service**; **Services that are not health care Services, supplies, or items; Sexual reassignment surgery**; **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).; **Vision hardware and optical Services**. Unless the Vision Hardware and 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; Weight control or Obesity Services**.

Exclusions that Apply Only to Tier 2 and Tier 3

Infertility treatment Services; Telehealth and Telemedicine; Transplants and transplant Services.

For Prior Authorization call Permanente Advantage at 1-800-822-3399. For the PPO, you may use First Health providers listed in the online directory at kp.org/addedchoice.

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.