

Summary of medical benefits

01/01/2010 through 12/31/2010

HARRISON ELECTRICAL WORKERS	02454
Annual individual deductible	\$100¹
Annual family deductible	\$300¹
Annual individual out-of-pocket maximum	\$2,000²
Annual family out-of-pocket maximum	\$6,000²
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	\$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	\$20 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
Urgent care visit	\$35
Emergency department visit	20%⁷
Ambulance services	20%
Mental health services	
Inpatient and residential care	Same as hospital inpatient care
Day treatment	Same as primary care per day
Outpatient treatment	Same as primary care
Chemical dependency services	
Inpatient and residential care	Same as hospital inpatient care
Day treatment	Same as primary care per day
Outpatient treatment	Same as primary care

Benefit (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	You pay
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%
Prescription eyeglasses and contact lenses	Balance after \$150 allowance every 24 months. ⁹

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. 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. 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. ⁹Professional fees for cosmetic contact lenses not covered. If the full credit is not used in the first visit, the balance is forfeited. No charge for standard frames and lenses post cataract surgery.