



# KAISER PERMANENTE®

## Type of Plan

Health Maintenance Organization (HMO)

## Service Area

The Kaiser Permanente service area is approximately a 30-mile radius of any Kaiser Permanente facility. The service area is defined by zip codes. If you live in one of the zip codes listed here, your coverage will be provided through the Kaiser Permanente Medical Plan.

You are eligible for enrollment and continued coverage as long as you reside in the service area. The service area consists of the following counties within the following ZIP codes:

### In Oregon

**Benton:** 97330, 97331, 97333, 97339, 97370

**Clackamas:** 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034, 97035, 97036, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97086, 97089, 97222, 97267, 97268

**Columbia:** All ZIP codes

**Hood River:** 97014

**Linn:** 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389

**Marion:** 97002, 97020, 97026, 97032, 97071, 97137, 97301, 97302, 97303, 97305, 97306, 97307, 97308, 97309, 97310, 97311, 97312, 97313, 97314, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383, 97384, 97385, 97392

**Multnomah:** All ZIP codes

**Polk:** All ZIP codes

**Washington:** All ZIP codes

**Yamhill:** All ZIP codes

### In Washington

**Clark:** All ZIP codes

**Cowlitz:** All ZIP codes

**Lewis:** 98591, 98593, 98596

**Skamania:** 98639, 98648

**Wahkiakum:** 98612, 98647

## Out of Network Care

Not covered, except for emergency and urgent care when you are not able to get to a Kaiser Permanente facility.

## Covered Providers

You must use Kaiser Permanente providers and facilities to be eligible for benefit coverage under this plan. Kaiser encourages you to choose a primary care physician to coordinate your medical care and authorize referrals to other Kaiser physicians and specialists.

You can review the providers at each Kaiser facility by going to [www.kaiserpermanente.org](http://www.kaiserpermanente.org) or you can request a list of physicians and facilities by telephone to HUBB or Kaiser Permanente Member Services.

## Dependent Age Limits

Your group plan covers enrolled dependents to age 23 (see definition of eligible family members on page #5).

## Member Services (M-F, 8am-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



KAISER PERMANENTE®

# Summary of Medical Plan Benefits

April, 2008 – March 31, 2009

OREGON HOME CARE COMMISSION	11428-001
<b>Annual individual deductible</b>	None
<b>Annual family deductible</b>	None
<b>Annual individual out-of-pocket maximum</b>	\$600 <sup>1</sup>
<b>Annual family out-of-pocket maximum</b>	\$1,200 <sup>2</sup>
<b>Lifetime benefit maximum</b>	None

<b>Benefit</b> (when provided, prescribed, or authorized by a Kaiser Permanente Plan provider)	<b>You pay</b>
<b>Office visits</b>	
Preventive care	\$20
Primary care, including urgent care	\$20
Specialty care	\$20
Prenatal care	No charge
Routine eye exam	\$20
Allergy shots and other injections	\$5
Routine immunizations	No charge
Rehabilitative therapies	\$20
Outpatient surgery	\$20
<b>X-rays, imaging, laboratory, and special diagnostic procedures</b>	No charge
<b>Outpatient prescription drugs</b>	\$10 generic/ \$20 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. <sup>3</sup>
<b>Hospital inpatient care</b>	No charge <sup>4</sup>
<b>Hospital maternity care for mother and newborn</b>	Same as hospital inpatient care.
<b>Emergency department visit– Kaiser-affiliated hospital</b>	\$75
<b>Emergency department visit– Kaiser Emergicenter or Urgent Care Clinics</b>	\$20
<b>Ambulance services</b>	\$75
<b>Mental health services</b>	
Inpatient psychiatric care	No charge
Residential Inpatient care	No charge; limit of 45 days per cal. yr.
Residential Day Treatment	\$20 copay per day
Outpatient therapy with mental health professionals	\$20 copay
<b>Chemical dependency services</b>	
Inpatient care	No charge
Residential care	No charge
Outpatient treatment	\$20 copay



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# Summary of Medical Plan Benefits

April, 2008 – March 31, 2009

<b>Benefit</b> (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	<b>You pay</b>
<b>Skilled nursing facility care</b>	No charge for up to 100 days per year
<b>Home health care</b>	No charge within service area
<b>Infertility services</b>	50% for diagnosis and treatment
<b>Durable medical equipment</b>	20%
<b>Interrupted Pregnancy Services</b>	\$20
<b>Prescription eyeglasses and contact lenses</b>	Balance after \$150 credit is applied. Your benefit renews every 24 months

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:** <sup>1</sup>Per calendar year. <sup>2</sup>Per calendar year. Maximum can be met by one family member. <sup>3</sup>Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria. <sup>4</sup>Includes room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs.



OREGON HOME CARE COMMISSION

11428-001

**Dental office visit charge**

\$10\*

**Annual deductible**

None

**Annual benefit maximum**

\$1,500

**Benefit** (when provided, prescribed, or authorized by a Kaiser Permanente Plan dentist)

**You pay**

**Preventive and diagnostic services**

Oral exams and X-rays, teeth cleaning, fluoride treatments, instruction in care of your teeth and gums, and prescribed space maintainers

\$10

**Basic restorative services**

Routine fillings, plastic and stainless steel crowns

20%

**Simple extractions**

20%

**Oral surgery**

Surgical tooth extractions, including diagnosis and evaluation

20%

**Periodontics**

Diagnosis, evaluation, and treatment of gum disease, including scaling and root planning

20%

**Endodontics**

Root canal and related therapy, including diagnosis and evaluation

20%

**Major restorative services**

Gold or porcelain crowns, inlays, and bridge abutments and pontics

50%

**Removable prosthetic services**

Full and partial dentures, relines and rebases

50%

**Emergency treatment**

From Plan providers:

\$25 for emergency and urgent care visits on the same or next business day plus any other charges that normally apply.

From non-Plan providers:

Balance after you are reimbursed up to \$100 for qualifying claims outside the service area.

**Orthodontics**

Not a covered benefit

**Please note:** \*applies to each office visit

- You pay \$15 for nitrous oxide for adults and children 13 and older.
- You pay 10 percent of charges for night guards.

**Limitations and Exclusions**

Benefits for work-in-progress are excluded for the following services and related materials: a) a prosthetic or other appliance, or modification of one, where an impression was made before your coverage became effective; b) a crown, bridge, or gold restoration for which a tooth was prepared before your coverage became effective; c) root canal therapy if the pulp chamber was opened before your coverage became effective is covered at 50 percent of charges.

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