

Kaiser Permanente Added Choice Full-Time Benefit Summary [Discontinues Jan. 1, 2010]

IN-NETWORK BENEFIT SUMMARY

This “In-Network Benefit Summary” is a summary of the most frequently asked questions about benefits of your In-Network benefits. Please refer to your “Out-of-Network Benefit Summary” for your out-of-network benefits. These charts do not describe benefits (including exclusions and limitations) for complete explanations and for additional benefits that are not included in this “In-Network Benefit Summary”, please refer to the “In-Network Copayments, Coinsurance and Benefits,” the “Exclusions and Limitations” and “Reductions” sections of this EOC.

	IN-NETWORK
Annual Out-Of-Pocket Maximum	
For one Member	\$600
For an entire Family Unit	\$1,200
Annual Deductible This plan does not have an annual deductible	
For one Member	None
For an entire Family Unit	None
Lifetime Maximum	None
Outpatient Care	
You Pay	
Routine preventive physical exam (includes adult and well child)	No charge
Primary care visit (includes OB/GYN visits, routine medical office visits, routine hearing exam appointments, and Urgent Services and Diabetic Outpatient self-management training and education, including medical nutrition therapy) The annual Benefit Maximum for preventive care is \$300 per member.	\$10
Specialty care visit (includes TMJ therapy and Diabetic Outpatient self-management training and education, including medical nutrition therapy; see Primary care for OB/GYN visits)	\$10
Scheduled prenatal care and first postpartum visit	No charge
Routine eye exam	\$10
All injections provided in the Nurse Treatment Area	\$5
Immunizations	No charge
Rehabilitative therapy visit	\$10
Outpatient surgery visit	\$10
Emergency Department visit	\$75 plus any other charges that normally apply
Breast, cervical, prostate, and colorectal cancer screenings	\$0
X-rays, imaging, laboratory, and special diagnostic procedures	No charge

State of Oregon
Public Employees' Benefit Board Summary Plan Description

	IN-NETWORK
Hospital Inpatient Care	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	\$100 per day up to \$500 maximum per year
Outpatient prescription drugs, supplies, and supplements	You Pay
Per Prescription	\$5 for generic drugs. \$15 for brand drugs. No charge for diabetic supplies, insulin, and smoking cessation drugs when used in conjunction with an approved smoking cessation program. 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.
Ambulance Services per transport	You Pay
	\$75 per transport
Durable Medical Equipment	You Pay
	No charge
Mental Health Services	You Pay
Outpatient Services	\$10
Intensive outpatient Services	\$10 per day
Inpatient Hospital Services	\$100 per day up to \$500 maximum per admission per year
Residential or day treatment Services Limited to 45 days per Calendar Year	\$100 per day up to \$500 maximum per admission per year
Chemical Dependency Services	You Pay
Outpatient Services	\$10
Inpatient Hospital Services	\$100 per day up to \$500 maximum per admission per year
Residential or day treatment Services Limited to 45 days per Calendar Year	\$100 per day up to \$500 maximum per admission per year
Home Health Services	You Pay
	No charge
Infertility Services	You Pay
	50% for diagnosis and treatment
Skilled Nursing Facility Care	You Pay
	No charge for up to 100 days per year
Hospice Care	You Pay
	No charge
Alternative Care	You Pay
	\$15 per chiropractor, acupuncture, or naturopath visit. \$1,000 benefit maximum per year
Hearing Aids	You Pay

State of Oregon
Public Employees' Benefit Board Summary Plan Description

	IN-NETWORK
	10% up to a maximum of \$4,000 every four years
Vision hardware	You Pay
Prescription eyeglasses and contact lenses	Balance after \$200 credit is applied. Your benefit renews every 24 months

OUT-OF-NETWORK BENEFIT SUMMARY

This “Out-of-Network Benefit Summary” is a summary of the answers to the most frequently asked questions about benefits. Please refer to your “In-Network Benefit Summary” for your in-network benefits. These charts do not describe benefits (including exclusions and limitations) for complete explanations, and for additional benefits that are not included in this “Out-of-Network Benefit Summary”, please refer to the “Out-of-Network Copayments, Coinsurance, Benefits and Other Requirements” section and the “Emergency Services, Urgent Services, and Routine Services” section as well as “Exclusions and Limitations,” and “Reductions” sections of this EOC.

	PPO	OTHER PROVIDERS
Annual Out-Of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$1,500 per Calendar Year	\$2,500 per Calendar Year
Family Out-of-Pocket Maximum	\$4,500 per Calendar Year	\$7,500 per Calendar Year
Annual Deductible		
This plan does not have an annual Deductible		
Individual Deductible	None	None
Family Deductible	None	None
Lifetime Maximum	\$2,000,000	\$2,000,000
Outpatient Care	You Pay	You Pay
Routine preventive physical exam (includes adult and well child)	No charge	30%
Primary care visit (includes OB/GYN visits, routine medical office visits, routine hearing exam appointments, and Urgent Services and Diabetic Outpatient self-management training and education, including medical nutrition therapy) The annual Benefit Maximum for preventive care is \$300 per member.	\$20	30%
Specialty care visit (includes TMJ therapy and Diabetic Outpatient self-management training and education, including medical nutrition therapy; see Primary care for OB/GYN visits.)	15%	30%
Scheduled prenatal care and first postpartum visit	15%	30%
Routine eye exam	Not covered	Not covered

State of Oregon
Public Employees' Benefit Board Summary Plan Description

	PPO	OTHER PROVIDERS
All injections provided in the Nurse Treatment Area	15%	30%
Immunizations	No charge	No charge
Rehabilitative therapy visit	15%	30%
Outpatient surgery visit	15%	30%
Urgent Care visit	\$20	30%
Emergency Department visit	In-network benefit applies: \$75 plus any other charges that normally apply	In-network benefit applies: \$75 plus any other charges that normally apply
X-rays, imaging, laboratory, and special diagnostic procedures	15%	30%
Hospital Inpatient Care	You Pay	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	15%	30%
Outpatient prescription drugs, supplies, and supplements	You Pay	You Pay
Per prescription	See "Other Providers"	\$20 for generic drugs at PBM-participating pharmacies. For brand drugs, you pay the difference in retail price between generic and brand plus \$20. No charge for diabetic supplies, insulin, and smoking cessation drugs when used in conjunction with an approved smoking cessation program. You get up to a 30-day supply.
Ambulance Services per transport	You Pay	You Pay
	See "Other Providers"	30%
Durable Medical Equipment	You Pay	You Pay
	In-network benefit applies: 0% coinsurance (No charge); available only through in-network providers.	
Mental Health Services	You Pay	You Pay
	15%	30%
Chemical Dependency Services	You Pay	You Pay
	15%	30%
Home Health Services	You Pay	You Pay
	15%	30%

State of Oregon
Public Employees' Benefit Board Summary Plan Description

	PPO	OTHER PROVIDERS
Infertility Services	You Pay	You Pay
	50% for diagnosis; treatment not covered	50% for diagnosis; treatment not covered
Skilled Nursing Facility Care	You Pay	You Pay
	15%	30%

Kaiser Permanente Added Choice Part-time and Retiree Benefit Summary
[Discontinues Jan. 1, 2010]

IN-NETWORK BENEFIT SUMMARY

This “In-Network Benefit Summary” is a summary of the most frequently asked questions about benefits and their Deductibles, Copayments and Coinsurance for your in-network benefits. Please refer to your “Out-of-Network Benefit Summary” for your out-of-network benefits. These charts do not describe benefits (including exclusions and limitations) for complete explanations and for additional benefits that are not included in this “In-Network Benefit Summary”, please refer to the “In-Network Deductibles, Copayments, Coinsurance and Benefits,” the “Exclusions and Limitations” and “Reductions” sections of this EOC.

	IN-NETWORK
Annual Out-Of-Pocket Maximum	
For one Member	\$2,000 per Calendar Year
For an entire Family Unit	\$6,000 per Calendar Year
Annual Deductible	
Deductible amounts do not apply toward your Annual Out-of-Pocket Maximum	
For one Member	\$250 per Calendar Year
For an entire Family Unit	\$750 per Calendar Year
Lifetime Maximum	None
Outpatient Care	You Pay
Routine preventive physical exam (includes adult and well child)	\$30
Primary care visit (includes OB/GYN visits, routine medical office visits, routine hearing exam appointments, and Urgent Services and Diabetic Outpatient self-management training and education, including medical nutrition therapy) The annual Benefit Maximum for preventive care is \$300 per member.	\$30; urgent services visits subject to deductible
Specialty care visit (includes TMJ therapy and Diabetic Outpatient self-management training and education, including medical nutrition therapy; see Primary care for OB/GYN visits)	\$30
Scheduled prenatal care and first postpartum visit	\$30