

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Kaiser Permanente HMO Full-time Benefit Summary

This is a summary of the most frequently asked questions about benefits and the Copayments and Coinsurance. This chart does not describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), and for complete explanations, and for additional benefits that are not included in this summary, please refer to the “Copayments, Coinsurance, and Benefits,” “Exclusions and Limitations” and “Reductions” sections of the Evidence of Coverage.

Out-of-Pocket Maximum	
For one Member	\$600
For an entire Family	\$1,200
Deductible	
For one Member	None
For an entire Family	None
Lifetime Maximum	None
Outpatient Services	You Pay
Routine preventive physical exam (<i>includes adult and well child</i>)	\$0
Primary care visit, including urgent care	\$5
Specialty care visit	\$5
Scheduled prenatal care and first postpartum visit	\$0
Routine eye exam	\$5
All injections provided in the Nurse Treatment Area	\$5
Immunizations	\$0
Outpatient surgery visit	\$5
Breast, cervical, prostate, and colorectal cancer screenings	\$0
Chemotherapy/radiation therapy	\$5
Emergency department visit (waived if admitted)	\$75 plus any other charges that normally apply
Inpatient Hospital Services	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	\$50 per day, up to \$250 maximum per admission
Ambulance Services	You Pay
Per transport	\$75
Chemical Dependency Services	You Pay
Outpatient Services	\$5

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Inpatient hospital Services	\$50 per day, up to \$250 maximum per admission
Residential Services	\$50 per day, up to \$250 maximum per admission
Day treatment Services	\$5 per day
Dialysis Services	You Pay
Outpatient dialysis	\$0
Home dialysis	\$0
Inpatient hospital	\$0
Skilled nursing facility (up to 100 days per Calendar Year)	\$0
Hearing Aids	You Pay
Hearing exams	\$5
Hearing aids (up to \$4,000 every four years)	10%
Home Health Services	You Pay
\$0	
Hospice Services	You Pay
\$0	
Infertility Services	You Pay
Diagnosis, treatment, and artificial insemination	50%
Mental Health Services	You Pay
Outpatient and intensive outpatient Services	

Outpatient Services	\$5
Intensive outpatient Services	\$5 per day
Inpatient Hospital Services	\$50 per day, up to \$250 maximum per admission
Residential Services	\$50 per day up to \$250 maximum per admission
Outpatient Durable Medical Equipment	You Pay
	\$0
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	You Pay
	\$0
Outpatient Prescription Drugs, Supplies, and Supplements	You Pay
No charge for diabetic supplies, insulin , and smoking cessation drugs when used in conjunction with an approved smoking cessation program	\$0

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Generic drugs, supplies, or supplements for up to a 30-day supply	\$1
Brand-name drugs, supplies, or supplements for up to a 30-day supply	\$15
Generic drugs, supplies, or supplements from our Mail-Delivery Pharmacy	
for up to a 30-day supply	\$1
for 31-90 days supply	\$2
Brand-name drugs, supplies, or supplements from our Mail-Delivery Pharmacy	
for up to a 30-day supply	\$15
for 31-90 days supply	\$30
Medical foods and formulas	\$0
Oral chemotherapy medications used for the treatment of cancer	\$0
Post-surgical immunosuppressive drugs after covered transplant services	\$0
Rehabilitative Therapy	You Pay
Outpatient occupational therapy (up to 20 visits per Calendar Year)	\$5
Outpatient physical therapy (up to 20 visits per Calendar Year)	\$5
Outpatient speech therapy (up to 20 visits per Calendar Year)	\$5
Outpatient respiratory therapy	\$5
Multidisciplinary rehabilitation (up to a combined total of 60 days per condition per Calendar Year for inpatient and outpatient rehabilitation)	
Inpatient multidisciplinary rehabilitation	\$50 per day, up to \$250 maximum per admission
Outpatient multidisciplinary rehabilitation	\$5
Skilled Nursing Facility Care	You Pay
Up to 100 days per Calendar Year	\$0
Vision Services (Eyeglasses and contact lenses)	You Pay
Prescription eyeglasses and contact lenses (up to \$200 every 24 months)	Charges in excess of \$200

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Student Out-of-area Coverage	
Routine, continuing, and follow-up Services (up to \$1200 per Calendar Year)	20% of the allowed amount plus any fees that exceed the allowed amount. The allowed amount is the lesser of 1) the provider's actual fee, or 2) the 70 th percentile of the fees for the same or similar Service in the geographic area where the Service was received, according to the most current survey data published by Medicode's Ingenix UCR Database.
Questions? Call Membership Services (M-F, 8am – 6pm) Portland: 503-813-2000, outside Portland: 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 of your benefit coverage, claims review, and adjudication procedures, please see your evidence of coverage (or EOC) or call Membership Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.	

Kaiser Permanente HMO Part-time and Retiree Benefit Summary

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Out-of-Pocket Maximum	
For one Member	\$1,500
For an entire Family	\$3,000
Deductible	
For one Member	None
For an entire Family	None
Lifetime Maximum	None
Outpatient Services	You Pay
Routine preventive physical exam (<i>includes adult and well child</i>)	\$0
Primary care visit, including urgent care	\$30
Specialty care visit	\$30
Scheduled prenatal care and first postpartum visit	\$0
Routine eye exam	\$30
All injections provided in the Nurse Treatment Area	\$5
Immunizations	\$0