

Summary of medical benefits

10/01/2006 through 09/30/2007

HILLSBORO SCHOOL DISTRICT - CLASSIFIED	01404
Annual individual deductible	None
Annual family deductible	None
Annual individual out-of-pocket maximum	\$600 ¹
Annual family out-of-pocket maximum	\$1,200 ¹
Lifetime benefit maximum	None
Benefit (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	You pay
Office visits for	
Preventive care	See primary care; no charge for age 0-2
Primary care, including urgent care	\$10
Specialty care	\$10
Prenatal care	No charge
Routine eye exam	\$10
Allergy shots and other injections	\$5
Routine immunizations	No charge
Rehabilitative therapies	See specialty care
Outpatient surgery	See specialty care
X-rays, imaging, laboratory, and special diagnostic procedures	No charge
Outpatient prescription drugs	\$10/prescription. 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. ²
Hospital inpatient care	No charge
Hospital maternity care for mother and newborn	Same as hospital inpatient care
Emergency department visit	\$50
Ambulance services	\$50
Mental health services	2-yr benefit period ends 12/31/07.
Inpatient psychiatric care.	\$100/day up to \$500/admission, for up to 16 days.
Residential/day treatment.	\$50/day up to \$250/admission, for up to 26 days.
Outpatient therapy with mental health professionals.	\$15 per visit for up to 40 visits.
Chemical dependency services	2-yr benefit period ends 12/31/07. ³
Inpatient medical treatment	20% ⁴
Residential/day treatment	20% ⁵

Benefit (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	You pay
Outpatient treatment	Primary care copayment per visit for up to 40 visits.
Skilled nursing facility care	No charge for up to 100 days per year
Home health care	No charge
Infertility services	50% for diagnosis and treatment
Durable medical equipment	20%
Alternative care	\$10/chiropractor, acupuncture, or naturopath visit. \$25/massage therapy visit for up to 12 visits per year. \$1,500 benefit maximum per year. ⁶
Prescription eyeglasses and contact lenses	Balance after \$200 credit is applied. Your benefit renews every 24 months.

Dependent age limits: Your group plan covers enrolled dependents to age 26.

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

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 A Guide to Your Benefits (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. ²Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria. ³Total benefit maximum: Kaiser Permanente pays up to \$8,125 for adult/\$13,125 for child under 18. ⁴Kaiser Permanente pays up to \$5,625 for adult/\$5,000 for child under 18. ⁵Kaiser Permanente pays up to \$4,375 for adult/\$3,750 for child under 18. ⁶Self referral to network providers.