

Summary of medical benefits

01/01/2008 through 12/31/2008

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|---|---|
| CITY OF VANCOUVER | 01959-101 |
| 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 | \$10 |
| Primary care, including urgent care | \$10 |
| Specialty care | \$10 |
| Prenatal care | \$10 |
| Routine eye exam | \$10 |
| Allergy shots and other injections | \$5 |
| Routine immunizations | No charge |
| Rehabilitative therapies | See specialty care ² |
| Outpatient surgery | See specialty care ³ |
| X-rays, imaging, laboratory, and special diagnostic procedures | No charge |
| Outpatient prescription drugs | \$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. ⁴ |
| Hospital inpatient care | No charge ⁵ |
| Hospital maternity care for mother and newborn | Same as hospital inpatient care |
| Emergency department visit | \$75 |
| Ambulance services | \$75 |
| Mental health services | 2-yr benefit period ends 12/31/09. |
| Inpatient psychiatric care. | Same as hospital inpatient care 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. | Same as primary care for up to 40 visits. |
| Chemical dependency services | 2-yr benefit period ends 12/31/09. ⁶ |
| Inpatient medical treatment | No charge |
| Residential/day treatment | No charge |

| Benefit (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician) | You pay |
|---|--|
| Outpatient treatment | Same as primary care |
| Skilled nursing facility care | No charge for up to 100 days per year |
| Home health care | No charge ⁷ |
| Infertility services | 50% for diagnosis and treatment |
| Durable medical equipment | 20% |
| Spinal and extremity manipulation therapy | \$10 per visit ⁸ |
| Prescription eyeglasses and contact lenses | Balance after \$150 credit is applied. Your benefit renews every 24 months. ⁹ |

Dependent age limits: Your group plan covers enrolled dependents to age 23.

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. ²Limited to 20 visits per therapy per year. ³Includes endoscopy procedures. ⁴Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria. ⁵Includes room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs. ⁶Total benefit maximum: Kaiser Permanente pays up to \$14,000 for 2008/\$14,500 for 2009. ⁷For up to 130 visits per year. ⁸Care must be provided by network providers. Up to 12 self-referred visits per year. Additional visits provided if treatment extension is approved by designated network. ⁹Professional fees for cosmetic contact lenses not covered.