



All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of medical benefits

Synod of The Pacific 4575-001

Oregon Traditional Plan

November 1, 2011 through October 31, 2012

Out-Of-Pocket Maximum (Not all services apply to the maximum; refer to your Evidence of Coverage for clarification.)	
For one Member	\$2,000 per Calendar Year
For an entire Family	\$4,000 per Calendar Year
Outpatient Services	You pay
Routine preventive physical exam (includes adult, well baby, and well child)	\$0
Primary care visit	\$15
Specialty care visit	\$15
Prenatal care visit	\$0
Routine eye exam	\$15
Allergy shots and other injections	\$10
Immunizations	\$0
Urgent Care visit	\$15
Emergency department visit	\$100
Outpatient surgery visit	\$100
Inpatient Hospital Services	\$250 per admission
Ambulance Services (per transport)	\$100
Chemical Dependency Services	
Outpatient Services	\$15
Inpatient hospital & residential Services	\$250 per admission
Mental Health Services	
Outpatient Services	\$15
Inpatient hospital & residential Services	\$250 per admission
Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics	20% Coinsurance
Hearing Aids for Children (up to \$4,080 every 48 months, per Member under age 18 and any child Dependent)	20% Coinsurance
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	\$0 per department visit
Outpatient Rehabilitative Therapy Services (up to 20 visits per therapy per Calendar Year)	\$15
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	\$0
Optional Benefits	
Alternative Care	Not covered
Hearing Aids	Not covered
Outpatient Prescription Drugs, Supplies, and Supplements	\$15 generic/\$30 brand up to 30-day supply; up to a 90-day supply of maintenance drugs for two Copayments.
Vision Hardware Optical Services	Not covered

Exclusions and Limitations

The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in your Evidence of Coverage, to be provided after you enroll for coverage.

Acupuncture. Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) your employer Group has purchased the Alternative Care (self-referred Acupuncture Services) rider.; **Certain exams and Services; Chiropractic Services received without a referral by Kaiser Permanente.** Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care Services or Chiropractic Services (self-referred Chiropractic Care) rider has been purchased.; **Cosmetic Services; Custodial Services; Dental Services.** Except when Medically Necessary for Members who have a medical condition that would place undue risk if performed in a dental office. The procedure must be approved.; **Designated blood donations; Detained or confined members; Employer responsibility; Experimental or investigational Services; Eye surgery; Family Services.** Services provided by a member of your immediate family.; **Genetic testing; Government agency responsibility; Hearing aids.** Unless the Hearing Aid rider has been purchased.; **Hypnotherapy; Intermediate Services; Massage therapy Services.** Limited to when: (a) a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care (Massage Therapy) benefit rider has been purchased.; **Naturopathy Services.** Limited to when: (a) referral for Services in accord with Medical Group criteria; or (b) Alternative Care (Naturopathy Services) rider has been purchased.; **Non-Medically Necessary Services; Nonreusable medical supplies; Outpatient Prescription Drugs.** Unless the Outpatient Prescription Drug rider has been purchased. Kaiser Permanente formulary applies. We cover non-formulary drugs only when you meet exception criteria unless specifically covered by your prescription drug plan.; **Services related to a non-covered Service; Sexual reassignment surgery; Supportive care and other Services; Travel and lodging.** Limited to: (a) Medically Necessary "Ambulance Services" in this *Summary*, and (b) certain expenses that we preauthorize.; **Vision hardware optical Services.** Unless the Vision Hardware Optical Services rider has been purchased.; **Vision therapy and orthoptics or eye exercises; Professional Services for fitting and follow-up care for contact lenses.** Unless the Vision Hardware Optical Services rider has been purchased.; **Low-vision aids.**

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 (EOC) or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.