

Summary of medical benefits

01/01/2007 through 12/31/2007

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| PACIFIC CONF. EVANGEL. CHURCH | 02600-001 |
| Annual individual deductible | None |
| Annual family deductible | None |
| Annual individual out-of-pocket maximum | \$600 ¹ |
| Annual family out-of-pocket maximum | \$1,200 ² |
| 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 | \$20 |
| Specialty care | \$20 |
| Prenatal care | No charge |
| Routine eye exam | \$20 |
| 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 | \$15 generic/\$30 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. ³ |
| Hospital inpatient care | \$100 per day, up to \$500 per admission ⁴ |
| Hospital maternity care for mother and newborn | Same as hospital inpatient care |
| Emergency department visit | \$75 |
| Ambulance services | \$75 |
| Mental health services | |
| Inpatient psychiatric care. | Same as hospital inpatient care |
| Residential/day treatment. | Residential treatment: Same as inpatient for up to 45 days per year Day treatment: Primary care copay per day |
| Outpatient treatment. | Primary care copayment |
| Chemical dependency services | |
| Inpatient care | Same as hospital inpatient care |

| Benefit (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician) | You pay |
|---|---|
| Residential/day treatment | Same as hospital inpatient care |
| Outpatient treatment | Primary care copayment |
| 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% |
| Prescription eyeglasses and contact lenses | Balance after \$150 credit is applied. Your benefit renews every 24 months. |

Dependent age limits: Your group plan covers enrolled dependents to age 21 or up to age 23 if registered as full-time students in a recognized educational institution.

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. ²Per calendar year. Maximum can be met by one family member. ³Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria. ⁴Includes room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs.