



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

George Fox University 1348-001

Oregon Traditional Plan

April 1, 2012 through March 31, 2013

<b>Out-Of-Pocket Maximum</b> (Not all services apply to the maximum; refer to your Evidence of Coverage for clarification.)	
For one Member	\$1,250 per Calendar Year
For an entire Family	\$2,500 per Calendar Year
<b>Preventive Care Services</b>	<b>You pay</b>
Routine preventive physical exam (includes adult, well baby, and well child)	\$0
Prenatal care and first postpartum visit	\$0
Immunizations	\$0
Preventive tests	\$0
<b>Outpatient Services</b>	
Primary care visit	\$20
Specialty care visit	\$20
Routine eye exam	\$20
Allergy shots and other injections	\$5
Urgent Care visit	\$40
Emergency department visit	\$75 (Waived if admitted)
Outpatient surgery visit	\$20
Physician-referred acupuncture (limited to 12 visits per Calendar Year)	\$20
<b>Inpatient Hospital Services</b>	\$250 per admission
<b>Ambulance Services</b> (per transport)	\$75
<b>Chemical Dependency Services</b>	
Outpatient Services	\$20
Inpatient hospital & residential Services	\$250 per admission
<b>Mental Health Services</b>	
Outpatient Services	\$20
Inpatient hospital & residential Services	\$250 per admission
<b>Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices</b>	20% Coinsurance
<b>Hearing Aids for Children</b> (up to \$4,211 every 48 months, per Member under age 18 and any child Dependent)	20% Coinsurance
<b>Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures</b>	\$0 per department visit
<b>Outpatient Rehabilitative Therapy Services</b> (up to 20 visits per therapy per Calendar Year)	
Physical, Speech, and Occupational therapies	\$20
All other therapies	\$20
<b>Skilled Nursing Facility Services</b> (up to 100 days per Calendar Year)	\$0
<b>Optional Benefits</b>	
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 when you use mail delivery.

Vision Hardware Optical Services  
Travel Services

Balance after \$150 allowance every 24 months  
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.; **Travel Services.** All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless the Travel Services rider has been purchased.; **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.