

# Kaiser Permanente

## SEIU 775 IPs

### Summary of medical benefits

SEIU IP Employees \$10 HMO, \$10/\$20 RX, Vision

12420-001

**Annual deductible**

None

**Annual out-of-pocket maximum**

\$750 per member

Not all copayments apply to this limit.

**Lifetime benefit maximum**

None

**Benefit** when provided, prescribed, or authorized by a Kaiser Permanente Plan physician

**You Pay**

**Office visits for**

Preventive care/ adult physical exams/ well-child care

No charge

Primary care - including urgent care

\$10

Specialty care

\$10

Prenatal and postnatal care

No charge

Routine eye exams

\$10

Allergy shots and other injections

\$5

Routine immunizations

No charge

Short-term rehabilitative therapies

Specialty care copayment

Outpatient surgery

\$50

**Laboratory tests**

No charge

**X-rays and special diagnostic procedures**

No charge

**Outpatient prescription drugs** at Kaiser Permanente Pharmacies

Drugs must be prescribed in accordance with the formulary process; we cover non-formulary drugs only when you meet exception criteria. You get up to a 30-day supply. When you use free home delivery, you get up to a 90-day supply of drugs we consider maintenance drugs for two copayments.

\$10 for generic drugs;  
\$20 for brand-name drugs

**Hospital inpatient care**

\$100 per admission

**Hospital maternity care for mother and newborn**

Hospital care copayment

**Emergency services**

at Kaiser Permanente network hospital emergency departments

\$50 plus any other copayments that normally apply

**Emergency services and urgent care**

at non-Kaiser Permanente facilities

See exclusions and limitations for details on qualifying care in and out of the service area. Your primary care copay applies for qualifying urgent care.

In-plan emergency copayment plus any other copayments that normally apply

**Ambulance service** (Medically necessary transportation only)

\$50

<b>Benefit</b> (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	<b>You Pay</b>
<b>Mental health services</b>	
Inpatient psychiatric care.	Same as hospital inpatient care for up to 10 days a year
Outpatient therapy with mental health professionals.	Primary care copayments per visit for up to 12 visits per year
<b>Chemical dependency services</b> (Care for Alcoholism and Drug Abuse)	
Inpatient medical treatment, residential/ day treatment, and outpatient medical treatment.	Usual copayments for office visits, lab, x-ray, etc.; Kaiser Permanente pays up to \$12,500 for any combination of services
<b>Skilled nursing facility care</b> (Up to 100 days per year.)	No charge
<b>Home health care</b>	No charge within service area
<b>Spinal and extremity manipulation therapy</b> Care must be provided by chiropractors who participate in the Kaiser Permanente network.	\$10 per visit for up to 12 self-referred visits per year; additional visits are provided if a treatment extension is approved by a designated network provider
<b>Infertility services</b>	50% of charges for diagnosis and treatment
<b>Prescription eyeglasses and contact lenses</b> Your benefit renews every 24 months.	See below
<b>Diabetic supplies</b> Your plan covers certain diabetic supplies.	20% of charges
<b>Vision</b> – If prescribed by Kaiser Permanente MD or Optometrist, the allowance may be applied to frames, lenses and/or contacts lenses. Exams for glasses or contacts provided per vision services office visit copayment. Members must use Kaiser Permanente facilities.	\$200 allowance every 24 months
<b>Benefit period</b> Members use their allowance once during a 24-month period. Multiple replacement eyeglass/cosmetic contact lenses are covered if a member's prescription changes .50 diopter or more within 12 months of the initial exam. Replacement lenses are covered up to the following maximum values:	
<ul style="list-style-type: none"> <li>• \$60 for single vision or cosmetic lenses.</li> <li>• \$90 for multifocal lenses.</li> </ul> (Replacement is for the original product type only.)	
<b>Routine eye exams</b> Members are covered for routine eye exams and for treatment of eye disease and injury under their standard medical plan. No referral is necessary to make an eye exam appointment. Members pay a specified office visit copayment for these visits.	
<b>QUESTIONS? CALL MEMBERSHIP SERVICES (Monday-Friday, 8AM-6PM)</b>	
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. For more details on your benefit coverage, claims reviews, and adjudication procedures, please see "A Guide to Your Benefits" (or EOC) or call Membership Services. Your group's service agreement is the binding document between Kaiser Foundation Health Plan of the Northwest and its members. In the case of conflict between this summary and the service agreement, the service agreement will prevail.*