



cis benefits
www.cisbenefits.org



KAISER PERMANENTE®

Effective August 1, 2011

Medical w/Rx & Vision	
Lifetime Maximum	Unlimited
Annual Deductible	None
Annual Out-of-Pocket Maximum	\$600 per individual, \$1,200 per family (per calendar year)
Preventive Services	
Well Baby Care	\$0 copay for children age 2 and under
Women's Exams: Pap Smear and Mammogram	\$0 office visit copay; x-ray and lab services 100% covered
Preventive Medical Exams	\$0 copay
Routine Immunizations for All Ages	100% covered
Therapeutic Injections	\$10 copay for office visit injections may apply
Physician Services	
Office Visit	\$10 copay
Eye Exams	\$10 copay
Hospital Visit	100% covered
Chiropractor	Not covered
Urgent Care Services	\$30 copay
Diagnostic X-ray and Lab	100% covered
Facility	
Inpatient Room and Board	100% covered
Emergency Outpatient	\$75 copay plus any supplemental charges that normally apply; waived if admitted
Surgical	
Surgeon and Anesthesiologist	100% covered inpatient; \$10 copay per visit outpatient
Rehabilitative Therapy	
Inpatient Therapies	100% covered
Outpatient Therapies	\$10 copay per therapy session; 20 visits per therapy per year. No limit for respiratory, radiation, chemotherapy or outpatient hemodialysis.
Mental Health	
▪ Inpatient	100% covered – same as hospital inpatient care
▪ Residential/Day Treatment	Residential: same as inpatient. Day Treatment: \$10 copay per day
▪ Outpatient Treatment	\$10 copay per visit
Chemical Dependency	
▪ Inpatient Detox	100% covered – same as hospital inpatient care
▪ Residential/Day and Other Inpatient Treatment	Residential: Inpatient benefit 100% covered. Day treatment: Primary office visit copay per day \$10.
▪ Outpatient Treatment	\$10 copay per visit
Other Services	
Ambulance	\$75 copay per medically necessary transport
Home Health Care	No charge; 130 visits per year
Durable Medical Equipment	80% covered; Medicare criteria applies
Special Accident	Covered as any other benefit
Hospice	100% covered for patient diagnosed with life expectancy of 6 months or less

Prescription Drugs (Not subject to Out-of-Pocket Maximum)	
Plan Pharmacy (Retail)	\$10 copay for up to 30-day supply generic or brand formulary drug; non-formulary not covered unless exception criteria met
Mail Order Pharmacy	\$20 copay per 90-day supply generic or brand maintenance formulary drug; non-formulary not covered unless exception criteria met
Vision Benefits	
Vision Exam	\$10 copay
Lenses and Frames	\$150 allowance to be applied toward one prescription of lenses and frames per 24-month benefit period. Professional fees for cosmetic contact lenses not covered.
Elective Contact Lenses	\$150 allowance to be applied toward one prescription of contact lenses in lieu of lenses and frames per 24-month benefit period

Hearing Benefits	
Hearing Aids – Kids Only	20% coinsurance for one hearing aid per ear up to \$4,000 combined for both ears every 4 years.

This summary provides a brief description of your health care plan benefits. Any errors or omissions are unintentional. Please refer to your Evidence of Coverage brochure for detailed information, including limitations and exclusions that may apply to the benefits above. In the case of conflict between this summary and the EOC, the EOC will prevail. You can also contact Kaiser Membership Services at 1-800-813-2000; Portland area 503-813-2000; or Salem 503-361-5400 if you have questions.