

# Summary of Medical Benefits

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

Membership Services: 1-800-813-2000

**Oregon EC17 - General County**

**1/1/2017 - 12/31/2017**

**Clackamas County**

**Group Number: 1183**

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

## Deductible

For one Member per Year	\$250
For an entire Family per Year	\$500

**Out-of-Pocket Maximum** (Note: All Deductible, Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.)

For one Member	\$1,000
For an entire Family	\$2,000

## Office visits

### You pay

Routine preventive physical exam	\$0
Primary Care	\$10
Specialty Care	\$10
Urgent Care	\$10

## Tests (outpatient)

### You pay

Preventive Tests	\$0
Laboratory	\$0
X-ray, imaging, and special diagnostic procedures	\$0
CT, MRI, PET scans	\$0 per department visit

## Medications (outpatient)

### You pay

Prescription drugs (up to a 30 day supply)	\$10 generic/\$20 preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	\$20 generic/\$40 preferred brand
Administered medications, including injections (all outpatient settings)	\$0
Nurse treatment room visits to receive injections	\$0

## Maternity Care

### You pay

Scheduled prenatal care and first postpartum visit	\$0
Laboratory	\$0
X-ray, imaging, and special diagnostic procedures	\$0
Inpatient Hospital Services	10% Coinsurance after Deductible

## Hospital Services

### You pay

Ambulance Services (per transport)	\$75
Emergency department visit	\$75 (Waived if admitted)
Inpatient Hospital Services	10% Coinsurance after Deductible

## Outpatient Services (other)

### You pay

Outpatient surgery visit	\$10
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Chemotherapy/radiation therapy visit	\$10
Durable medical equipment, external prosthetic devices, and orthotic devices	\$0
Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	\$10
<b>Skilled Nursing Facility Services</b>	<b>You pay</b>
Inpatient skilled nursing Services (up to 100 days per Year)	\$0
<b>Chemical Dependency Services</b>	<b>You pay</b>
Outpatient Services	\$10
Inpatient hospital & residential Services	10% Coinsurance after Deductible
<b>Mental Health Services</b>	<b>You pay</b>
Outpatient Services	\$10
Inpatient hospital & residential Services	10% Coinsurance after Deductible
<b>Alternative Care*</b>	<b>You pay</b>
Alternative care (self-referred)	\$10 per visit for acupuncture, chiropractic, and naturopathic visits. \$25 per massage therapy visit (up to 12 visits per Year). \$1,500 benefit maximum for all Services combined.
<b>Vision Services</b>	<b>You pay</b>
Routine eye exam (through first month of age 19)	\$0
Vision hardware and optical Services (through first month of age 19)*	No charge for eyeglass lenses or frames or contact lenses every 12 months.
Routine eye exam (age 19 and older)	\$10
Vision hardware and optical Services (ages 19 years and older)*	Balance after \$250 allowance, once every year

\*Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample EOCs are available upon request or you may go to <http://www.kp.org/plandocuments>

**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000  
All other areas: 1-800-813-2000 TTY.711. 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 benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.