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

Oregon SP16 **October 1, 2016 - September 30, 2017**

NATA **Group Number: 14200**

Deductible	
For one Member per Calendar Year	$3,000
For an entire Family per Calendar Year	$9,000
Out-of-Pocket Maximum (Note: All Deductible, Copayment, and Coinsurance amounts count toward the Out of Pocket Maximum, unless otherwise noted.)	
For one Member	$5,000
For an entire Family	$10,000
Office visits	**You pay**
Routine preventative physical exam	$0
Primary Care	$30
Specialty Care	$40
Urgent Care	$50
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$30 per department visit
X-ray, imaging, and special diagnostic procedures	$30 per department visit
CT, MRI, PET scans	$100 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$20 generic/$40 preferred brand/$60 non-preferred brand/$150 specialty
Mail Order Prescription drugs (up to a 90 day supply)	$40 generic/$80 preferred brand/$120 non-preferred brand
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10
Maternity Care	**You pay**
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$30 per department visit
X-ray, imaging, and special diagnostic procedures	$30 per department visit
Inpatient Hospital Services	20% Coinsurance after Deductible
Hospital Services	**You pay**
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency department visit	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$40 after Deductible

Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$40
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Chemical Dependency Services	**You pay**
Outpatient Services (Group visit ½ copay)	$30
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	**You pay**
Outpatient Services (Group visit ½ copay)	$30
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care	**You pay**
Alternative care (self-referred)	Not covered
Vision Services	**You pay**
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)	$30
Vision hardware and optical Services (ages 19 years and older)*	Balance after $150 allowance, once every two calendar years

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

Additional Features

Online Access anytime, anywhere at no additional charge: kp.org

- Access medical records
- Refill Prescriptions
- Email doctor
- Check lab results
- Schedule appointments
- Health Risk Assessments – personal online tool for members

Member Discounts: kp.org/choosehealthy

- CHP Active and Healthy
- Fitness club discounts
- Vitamins and supplements
- Alternative and chiropractic care

Facilities and Services: kp.org/facilities

- 37 Medical offices
- 8 Urgent Care Services
- 17 Dental offices
- The Portland Clinic (7 locations)
- 24-hours advice nurses
- Health coach services

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 the *Evidence of Coverage (EOC)*. For a complete list and description of Exclusions and Limitations please refer to *EOC*.

Acupuncture unless your employer Group has purchased the "Alternative Care Services Rider". **Chiropractic** unless your employer Group has purchased the "Alternative Care Services Rider" or the "Chiropractic Services Rider" (for self-referred chiropractic care). **Cosmetic Services;** This exclusion does not apply to Services that are covered under "Reconstructive Surgery Services" in the "Benefits" section of the *EOC*. **Custodial Services. Dental Services. Designated Blood Donations. Employer Responsibility;** We do not reimburse the employer for any Services that the law requires an employer to provide. **Experimental or Investigational Services. Eye Surgery;** Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures. **Family Services;** Services provided by a member of your immediate family. **Genetic Testing. Hearing Aids** unless your Group has purchased the "Hearing Aid Rider." **Hypnotherapy. Infertility Services** unless your group has purchased the "Infertility Treatment Services Rider." **Intermediate Services;** Services in an intermediate care facility are excluded. **Low-Vision Aids. Massage Therapy Services** unless your employer Group has purchased the "Alternative Care Services Rider". **Naturopathy Services** unless your employer Group has purchased the "Alternative Care Services Rider". **Non-Medically Necessary Services. Services Related to a Non-Covered Service. Services That are Not Health Care Services, Supplies, or Items. Supportive Care and Other Services. Surrogacy.** Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. **Travel and Lodging. Travel Services.** All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless your Group has purchased the "Travel Services Rider." **Vision Hardware and Optical Services** unless your Group has purchased an "Adult Vision Hardware and Optical Services Rider" and/or "Pediatric Vision Hardware and Optical Services Rider." **Vision Therapy and Orthotics or Eye Exercises.**

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 Membership Services. In the case of conflict between this summary and the *EOC*, the *EOC* will prevail.