KAISER PERMANENTE®

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 C17a **7/1/2017 - 6/30/2018**

Linn County **Group Number: 2493-006**

Calendar year is the time period (Year) in which dollar, day, and visit limits, and Out-of Pocket Maximums accumulate.	
Deductible	
For one Member per Year	$0
For an entire Family per Year	$0
Out-of-Pocket Maximum (Note: All Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.)	
For one Member	$600
For an entire Family	$1,200
Office visits	**You pay**
Routine preventive physical exam	$0
Primary Care	$5
Specialty Care	$5
Urgent Care	$25
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$5 per department visit
X-ray, imaging, and special diagnostic procedures	$5 per department visit
CT, MRI, PET scans	$5 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$10 generic/$20 preferred brand/$40 non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	$20 generic/$40 preferred brand/$80 non-preferred brand
Administered medications, including injections (all outpatient settings)	20% Coinsurance
Nurse treatment room visits to receive injections	$5
Maternity Care	**You pay**
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$5 per department visit
X-ray, imaging, and special diagnostic procedures	$5 per department visit
Inpatient Hospital Services	$50 per day up to $250 per admission
Hospital Services	**You pay**
Ambulance Services (per transport)	$75
Emergency department visit	$200 (Waived if admitted)
Inpatient Hospital Services	$50 per day up to $250 per admission
Outpatient Services (other)	**You pay**

Outpatient surgery visit	$20
Chemotherapy/radiation therapy visit	$5
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance
Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	$5
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	$0
Chemical Dependency Services	**You pay**
Outpatient Services	$5
Inpatient hospital & residential Services	$50 per day up to $250 per admission
Mental Health Services	**You pay**
Outpatient Services	$5
Inpatient hospital & residential Services	$50 per day up to $250 per admission
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)	$5
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.