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

Member Services: 1-800-813-2000

Oregon C18G **1/1/2018 - 12/31/2018**

City & County of San Francisco **Group Number: 21227**

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	$0
For an entire Family per Year	$0
Out-of-Pocket Maximum *	
For one Member per year	$1,500
For an entire Family per year	$3,000
Office visits	**You pay**
Routine preventive physical exam	$0
Primary Care	$20
Specialty Care	$20
Urgent Care	$20
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)	$5 generic / $15 preferred brand / $15 non-preferred brand / 20% (up to $100 maximum) specialty
Mail Order Prescription drugs (up to a 90 day supply)	$5 generic / $15 preferred and 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	$0
X-ray, imaging, and special diagnostic procedures	$0
Inpatient Hospital Services	$200 per admission
Hospital Services	**You pay**
Ambulance Services (per transport)	$0
Emergency department visit	$100 (Waived if admitted)
Inpatient Hospital Services	$100 per admission
Outpatient Services (other)	**You pay**
Outpatient surgery visit	$35

Chemotherapy/radiation therapy visit	$20
Durable medical equipment, external prosthetic devices, and orthotic devices	$0
Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	$20
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	$0
Chemical Dependency Services	**You pay**
Outpatient Services	$20
Inpatient hospital & residential Services	$100 per admission
Mental Health Services	**You pay**
Outpatient Services	$20
Inpatient hospital & residential Services	$100 per admission
Alternative Care (self referred) **	**You pay**
Benefit Maximum per Year (not applicable)	Not Applicable
Acupuncture Services	Not Covered
Chiropractic Services	$20
Massage Therapy	Not Covered
Naturopathic Medicine	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)	Not covered
Routine eye exam (age 19 and older)	$0
Vision hardware and optical Services (age 19 years and older)	Not covered

*Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

** Refer to your Evidence of Coverage (EOC) for any applicable visits limits.

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.