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 De17 **7/1/2017 - 6/30/2018**

Janus Youth Programs, Inc. **Group Number: 13014-011**

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of Pocket Maximums accumulate.			
Deductible (The amounts you pay for covered Services subject to the Deductible in Tier 1 and Tier 2 cross accumulate. This means that the amounts you pay for covered Services in Tier 1 also count toward the Deductible in Tier 2, and do not count toward the Deductible in Tier 3. The amounts you pay for covered Services subject to the Deductible in Tier 3 only count toward the Deductible in Tier 3.)			
For one Member per Year	$500	$1,000	$1,500
For an entire Family per Year	$1,500	$3,000	$4,500
Out-of-Pocket Maximum (All Deductible, Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted. The amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in Tier 1 and Tier 2 cross accumulate. This means that the amounts you pay for covered Services in Tier 1 also count toward the Out-of-Pocket Maximum in Tier 2, and do not count toward the Out-of-Pocket Maximum in Tier 3. The amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in Tier 3 only count toward the Out-of-Pocket Maximum in Tier 3.)			
For one Member	$3,000	$4,750	$6,000
For an entire Family	$6,000	$9,500	$12,000
Office visits		**You pay**	
Routine preventive physical exam	$0	$30	45% Coinsurance after Deductible
Primary Care	$20	$30	45% Coinsurance after Deductible
Specialty Care	$30	$40	45% Coinsurance after Deductible
Urgent Care	$40	$50	45% Coinsurance after Deductible
Tests (outpatient)		**You pay**	
Preventive Tests	$0	$30	45% Coinsurance after Deductible
Laboratory	$20 per department visit	$30 per department visit	45% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	$30 per department visit	45% Coinsurance after Deductible
CT, MRI, PET scans	$100 per department visit	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Medications (outpatient)		**You pay**	

Prescription drugs (up to a 30 day supply)	$15 generic/$30 preferred brand/$50 non-preferred brand	At MedImpact Pharmacy $20 generic/$40 preferred brand/$60 non-preferred brand	
Mail Order Prescription drugs (up to a 90 day supply)	$30 generic/$60 preferred brand/$100 non-preferred brand	Mail-Delivery Pharmacy 1-800-548-9809 kp.org/addedchoice	
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10	$30	45% Coinsurance after Deductible
Maternity Care		**You pay**	
Scheduled prenatal care and first postpartum visit	$0	$30	45% Coinsurance after Deductible
Laboratory	$20 per department visit	$30 per department visit	45% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	$30 per department visit	45% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Hospital Services		**You pay**	
Ambulance Services (per transport)	20% Coinsurance after Deductible		
Emergency department visit	$200 after Deductible (Waived if admitted)		
Inpatient Hospital Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Outpatient Services (other)		**You pay**	
Outpatient surgery visit	20% Coinsurance after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$30 after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	$30	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Skilled Nursing Facility Services		**You pay**	
Inpatient skilled nursing Services (up to 100 days per Year)	$0 after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Chemical Dependency Services		**You pay**	
Outpatient Services	$20	$30	45% Coinsurance after Deductible
Inpatient hospital & residential Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Mental Health Services		**You pay**	
Outpatient Services	$20	$30	45% Coinsurance after Deductible

Inpatient hospital & residential Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Alternative Care*		**You pay**	
Alternative care (self-referred)	$20 per visit for acupuncture, chiropractic, and naturopathic visits. $25 per massage therapy visit (up to 12 visits per Year). $1,000 benefit maximum for all Services combined.	$20 per visit for chiropractic, naturopathic and acupuncture visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,000 benefit maximum for all Services combined.	
Vision Services		**You pay**	
Routine eye exam (through first month of age 19)	$20	$30	45% Coinsurance after Deductible
Vision hardware and optical Services (through first month of age 19)*	Not covered		Not covered
Routine eye exam (age 19 and older)	$20	$30	45% Coinsurance after Deductible
Vision hardware and optical Services (ages 19 years and older)*	Not covered		

*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.