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

Member Services: 1-800-813-2000

Oregon PT18 **7/1/2018 - 6/30/2019**

Janus Youth Programs, Inc. **Group Number: 13014-007**

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	$500
For an entire Family per Year	$1,500
Out-of-Pocket Maximum *	
For one Member per year	$2,000
For an entire Family per year	$6,000
Office visits	**You pay**
Routine preventive physical exam	$0
Primary Care	$20
Specialty Care	$30
Urgent Care	$40
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$20 per department visit
CT, MRI, PET scans	$100 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$15 generic / $30 preferred brand / $50 non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	$30 generic / $60 preferred brand / $100 non-preferred brand
Administered medications, including injections (all outpatient settings)	10% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10
Maternity Care	**You pay**
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$20 per department visit
Inpatient Hospital Services	10% Coinsurance after Deductible
Hospital Services	**You pay**
Ambulance Services (per transport)	10% Coinsurance after Deductible
Emergency department visit	10% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible
Outpatient Services (other)	**You pay**

Outpatient surgery visit	10% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$30 after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	10% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	$30
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	10% Coinsurance after Deductible
Chemical Dependency Services	**You pay**
Outpatient Services	$20
Inpatient hospital & residential Services	10% Coinsurance after Deductible
Mental Health Services	**You pay**
Outpatient Services	$20 per visit
Inpatient hospital & residential Services	10% Coinsurance after Deductible
Alternative Care (self referred) **	**You pay**
Benefit Maximum per Year (all Covered Services combined)	$1,000
Acupuncture Services	$20
Chiropractic Services	$20
Massage Therapy	$25
Naturopathic Medicine	$20
Vision Services	**You pay**
Routine eye exam (through first month of age 19)	$20
Vision hardware and optical Services (through first month of age 19)	Not covered
Routine eye exam (age 19 and older)	$20
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.