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 HPD6 **April 1, 2016 - March 31, 2017**

Willamette University **Group Number: 2014**

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers
Deductible			
For one Member per Calendar Year	$250	$500	$750
For an entire Family per Calendar Year	$750	$1,500	$2,250
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 per Calendar Year	$1,750	$3,000	$4,000
For an entire Family per Calendar Year	$5,250	$9,000	$12,000
Office visits		**You Pay**	
Routine preventive physical exam	$0	$0	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	$0	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)	$20 generic/$40 preferred brand/$60 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 at Select Provider pharmacies)	$40 generic/$80 preferred brand/$120 non-preferred brand	Refer to Tier 1, Select Provider, benefit for all mail order.	

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	$0	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**		
Emergency 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 30 visits combined per Calendar 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 Calendar Year)	$0 after Deductible	30% Coinsurance after Deductible	45% Coinsurance after Deductible
Chemical Dependency Services	**You Pay**		
Outpatient Services (Group visit ½ copay)	$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 (Group visit ½ copay)	$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 (Visit limits and benefit maximums cross accumulates between tiers)	$25 per visit for acupuncture, chiropractic, and naturopathic visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.	$25 per visit for chiropractic, naturopathic and acupuncture visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.

Vision Services	You Pay		
Routine eye exam (through first month of age 19)	$0	$0	45% Coinsurance after Deductible
Vision hardware and optical Services (through first month of age 19)	No charge for eyeglass lenses or frames or contact lenses every 12 months.		Balance after $250 allowance
Routine eye exam (age 19 and older)	$20	$30	45% Coinsurance after Deductible
Vision hardware and optical Services (ages 19 years and older)*	Balance after $250 allowance, once every calendar year		

* Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.
Note: In Tier 1 and Tier 2, Coinsurance is a percentage of Charges. In Tier 3, Coinsurance is a percentage of the Allowed Amount; you will also be responsible for paying any provider or facility fees in excess of the Allowed Amount.

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 office
- 8 Urgent Care Services
- 17 Dental offices
- The Portland Clinic (7 locations)
- 24-hours advise 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*.

Exclusions and Limitations that apply to all three tiers:
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 Orthoptics or Eye Exercises. Weight control or obesity Services** unless your group has purchased rider.
Exclusion and Limitations that apply to Tier 2 and Tier 3:
Transplants and transplant Services

For Prior Authorization call Permanente Advantage at 1-800-822-3399. For the PPO, you may use the PPO providers listed in the online directory at kp.org/addedchoice.

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 your 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.