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 Aa17 WISE CONSUMER HSA-QUALIFIED PLAN **1/1/2017 - 12/31/2017**

Chemeketa Community College **Group Number: 1176-024**

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	$1,500
For an entire Family per Year	$3,000
Out-of-Pocket Maximum (Note: All Deductible, Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted. The Deductible and Out-of-Pocket Maximum amounts are subject to increase if the U.S. Department of Treasury changes the minimum Deductible and Out-of-Pocket Maximum amounts required in High Deductible Health Plans.)	
For one Member	$2,500
For an entire Family	$5,000
Office visits	**You pay**
Routine preventative physical exam	$0
Primary Care	10% Coinsurance after Deductible
Specialty Care	10% Coinsurance after Deductible
Urgent Care	10% Coinsurance after Deductible
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	10% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible
CT, MRI, PET scans	10% Coinsurance after Deductible
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	After Deductible: $15 generic/$30 preferred brand/$50 non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	After Deductible: $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% Coinsurance after Deductible
Maternity Care	**You pay**
Scheduled prenatal care and first postpartum visit	$0
Laboratory	10% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible
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	10% Coinsurance after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	10% Coinsurance after Deductible
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	10% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible
Mental Health Services	**You pay**
Outpatient Services	10% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible
Alternative Care*	**You pay**
Alternative care (self-referred)	$15 per visit after Deductible for acupuncture, chiropractic and naturopathic visits. $25 after Deductible per massage therapy visit (up to 12 visits per Year). $1,000 benefit maximum for all Services combined.
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)	10% Coinsurance after Deductible
Vision hardware and optical Services (ages 19 years and older)*	Balance after $150 allowance, once every two years

*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.