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

Reed College 1780-001
Oregon Traditional Copayment Plan C14F
April 1, 2014 through March 31, 2015

Out-of-Pocket Maximum (All Copayment and Coinsurance amounts count toward the maximum, unless otherwise noted.)	
For one Member	$1,000 per Calendar Year
For an entire Family	$2,000 per Calendar Year
Preventive Care Services	**You pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit	$20
Specialty care visit	$20
Urgent care visit	$20
Emergency department visit	$75 (Waived if admitted)
Outpatient surgery visit	$20
Chemotherapy/radiation therapy visit	$20
Laboratory, X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0
Routine eye exam	$20
Nurse treatment room visits to receive injections	$5
Administered medications, including injections (all outpatient settings)	20% Coinsurance
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$20
Inpatient Hospital Services	$50 per day up to $250 per admission
Ambulance Services (per transport)	$75
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	20% Coinsurance
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	$0
Chemical Dependency Services	
Outpatient Services	$20
Inpatient hospital & residential Services	$50 per day up to $250 per admission
Mental Health Services	
Outpatient Services	$20
Inpatient hospital & residential Services	$50 per day up to $250 per admission
Student Out-of-Area Coverage Routine, continuing, and follow-up Services (up to $1,200 per Calendar Year; amounts do not count toward the maximum)	20% of the actual fee the provider, facility, or vendor charged for the Service

Optional Benefits (Amounts do not count toward the maximum.)	
Alternative care (self-referred)	Not covered
Hearing aids (ages 19 years and older)	Not covered
Outpatient prescription drugs	$15 generic/$30 brand. $0 for formulary contraceptives. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments. 50% Coinsurance for infertility drugs.
Vision hardware and optical Services (ages 18 years and younger)	Not covered
Vision hardware and optical Services (ages 19 years and older)	Not covered

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)*.

Acupuncture. Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) the Alternative Care (self-referred Acupuncture Services) rider has been purchased.; **Certain exams and Services**; **Chiropractic Services received without a referral.** Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care Services or Chiropractic Services (self-referred Chiropractic Care) rider has been purchased.; **Cosmetic Services**; **Custodial Services**; **Dental Services.** Except when Medically Necessary for Members who have a medical condition that would place undue risk if performed in a dental office. The procedure is subject to Utilization Review.; **Designated blood donations**; **Detained or confined members**; **Employer responsibility**; **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**; **Government agency responsibility**; **Hearing aids.** Unless the Hearing Aid rider has been purchased.; **Hypnotherapy**; **Intermediate Services**; **Massage therapy Services.** Limited to when: (a) a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care (Massage Therapy) rider has been purchased.; **Naturopathy Services.** Limited to when: (a) a Participating Physician makes a referral for Services in accord with Medical Group criteria; or (b) Alternative Care (Naturopathy Services) rider has been purchased.; **Non-Medically Necessary Services**; **Nonreusable medical supplies**; **Outpatient Prescription Drugs.** Unless the Outpatient Prescription Drug rider has been purchased. Our drug formulary applies. We cover non-formulary drugs only when you meet exception criteria unless specifically covered by your prescription drug plan.; **Professional Services for fitting and follow-up Services for contact lenses**; **Services performed by unlicensed people; Services related to a non-covered Service**; **Services that are not health care Services, supplies, or items; Supportive care and other Services**; **Travel and lodging.** Limited to: (a) Medically Necessary ambulance Services, and (b) certain expenses that we preauthorize.; **Travel Services.** All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless the Travel Services rider has been purchased.; **Vision hardware and optical Services (ages 18 and younger)**. Unless the Pediatric Vision Hardware and Optical Services rider has been purchased.; **Vision hardware and optical Services (ages 19 and older)**. Unless the Adult Vision Hardware and Optical Services rider has been purchased.; **Vision therapy and orthoptics or eye exercises.**

Questions? Call Membership Services (M-F, 8 am-6 pm) or visit **kp.org**
Portland area..503-813-2000. All other areas..1-800-813-2000. TTY..1-800-735-2900.
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 Membership Services. In the case of conflict between this summary and the *EOC*, the *EOC* will prevail.