UNDERSTANDING **DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS**

Deductibles

Under a deductible plan, many covered services are subject to the **deductible**—the **set amount** for which you pay full charge in a calendar year.

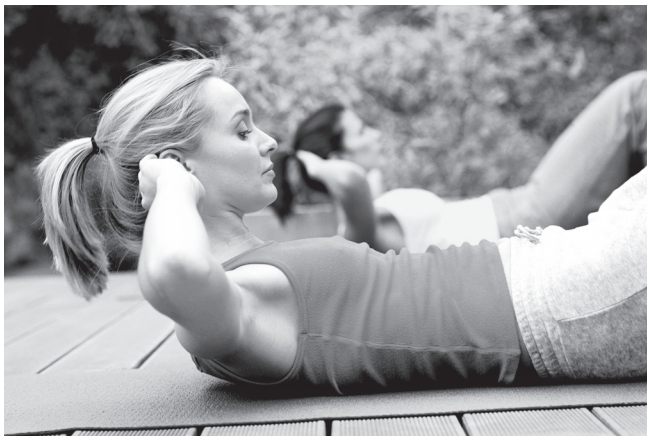
This means you'll pay full charge for certain medical services until you reach your deductible. Of course, an exception to the deductible requirement is preventive care, such as immunizations, routine physical exams, and preventive health screenings. Our preventive care services are no charge from the first day of coverage.

Out-of-pocket maximums

The **out-of-pocket maximum** is the **maximum amount** of coinsurance and copayments you have to pay out of pocket for certain covered services in a calendar year. If you meet your out-of-pocket maximum, you will not be required to pay anything out of pocket for certain covered services for the remainder of the calendar year.

In our deductible plans, the amount you pay to reach your deductible does not apply toward your out-of-pocket maximum.

Visit the treatment fee tool at **kp.org/treatmentestimates** to estimate the cost of your next appointment or your potential out-of-pocket medical costs for the year.



A quick guide to our plan names

We've designed our plan names so you can easily tell what each one offers. The first number indicates your deductible and the second is your copay or coinsurance. We've also indicated whether the plan includes prescription benefits or maternity coverage.

For example, our KP 1000/25/Rx plan has a $1,000 deductible (1000), a $25 copayment for select covered services (25), and it has prescription benefits (Rx). And our KP 2500/35/NM plan has a $2,500 deductible (2500), a $35 copay for primary care office visits (35), and no inpatient maternity benefits (NM).

◀ **Please open to view benefit highlights**

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Individuals and Families Plans

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CHOOSE A PLAN

PLANS & BENEFITS

What our plans offer
and how they work

IN THIS BROCHURE

- How our deductible plans work
- Understanding deductibles and out-of-pocket maximums
- Benefit highlights

All plans are offered and underwritten by
Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232

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SUPPORT YOUR GOALS WITH **A PLAN THAT SUPPORTS YOU**

How our deductible plans work

All of our plans are deductible plans. Deductible plans generally offer lower monthly premiums in exchange for higher out-of-pocket payments for covered services. With these plans, you pay full charge for many covered services until your expenses meet a calendar-year deductible. Then, for covered services, you pay a copayment or coinsurance.

No deductible for many services

With our Gold and Silver deductible plans, many services, such as primary care visits, urgent care, and prescription drugs, are available for a copayment or coinsurance before you meet your deductible.

To encourage you to receive preventive care, preventive care services are **available at no charge before** you meet your deductible. From the first day of coverage, you pay no charge for services such as annual checkups, preventive screenings, and immunizations.

In a family plan, there are two ways for enrolled family members to meet their deductible:

- Each family member can separately meet the individual deductible.
- The family's combined expenses can meet the family deductible.

For more information on deductible plans, visit **kp.org/deductibleplans**.

This brochure provides summaries of various plans and is not a contract. Plan details are provided in the *Plan Agreement*. For specific plan information about the plans referred to in this brochure, see the following forms: *EWIdDedGXX0110—Comprehensive Deductible Plan Agreement; ENDEWIdDedGXX0110—Endorsement; ENDEWIdDedGXX0111—Endorsement; BSWDEDG1000XX0111—Benefit Summary KP 1000/25/Rx; BSWDEDS1500XX0111— Benefit Summary KP 1500/30/Rx; BSWDEDS2500XX0111—Benefit Summary KP 2500/30/Rx; BSWDEDS3500XX0111—Benefit Summary KP 3500/30/Rx; BSWDEDS5000XX0111—Benefit Summary KP 5000/30/Rx; BSWDEDS7500XX0111—Benefit Summary KP 7500/30/Rx; FSWDEDG1000XX0111—Face Sheet KP 1000/25/Rx; FSWDEDS1500XX0111—Face Sheet KP 1500/30/Rx; FSWDEDS2500XX0111—Face Sheet KP 2500/30/Rx; FSWDEDS3500XX0111—Face Sheet KP 3500/30/Rx; FSWDEDS5000XX0111—Face Sheet KP 5000/30/Rx; FSWDEDS7500XX0111—Face Sheet KP 7500/30/Rx; RWRXGUXX0111—Outpatient Prescription Drug Rider* (Gold and Silver plans only)*; RWVHIXX0111—Vision Hardware Optical Services Rider* (Gold plan only)*; EWIdDedBXX0110—Catastrophic Deductible Plan Agreement; ENDEWIdDedBXX0110—Endorsement; ENDEWIdDedBXX0111—Endorsement; BSWDEDB2500XX0111—Benefit Summary KP 2500/35/NM; BSWDEDB3500XX0111—Benefit Summary KP 3500/35/NM; BSWDEDB5000XX0111—Benefit Summary KP 5000/35/NM; BSWDEDB7500XX0111—Benefit Summary KP 7500/35/NM; FSWDEDB2500XX0111—Face Sheet KP 2500/35/NM; FSWDEDB3500XX0111—Face Sheet KP 3500/35/NM; FSWDEDB5000XX0111—Face Sheet KP 5000/35/NM; FSWDEDB7500XX0111—Face Sheet KP 7500/35/NM.* To obtain a *Plan Agreement* for a particular plan, contact Membership Services.

Have a question? We're here to help. Call **1-800-494-5314**, 8 a.m. to 8 p.m., Monday–Friday; 9 a.m. to 5 p.m., Saturday.

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BENEFIT HIGHLIGHTS

	GOLD PLAN		
	KP 1000/25/Rx	KP 1500/ 30/Rx	KP 2500/ 30/Rx
Features			
Deductible (individual/family)	$1,000/$3,000	$1,500/$4,500	$2,500/$7,500
Out-of-pocket maximum (individual/family)	$5,000/$15,000	$7,500/$22,500	
Benefits	**Services not subject to deductible unless otherwise indicated**		
Preventive care			
Immunizations	No charge	No charge	
Routine physical	No charge	No charge	
Well-baby visit (ages 0–2)	No charge	No charge	
Mammogram	No charge	No charge	
Gynecological exam	No charge	No charge	
Lab tests and X-rays (preventive)	No charge	No charge	
Outpatient services (per visit or procedure)			
Primary care office visit	$25 copay	$30 copay	
Specialty care office visit	$35 copay	30% coinsurance (after deductible)	
Nurse treatment visit (includes allergy injections)[1]	$10 copay	30% coinsurance (after deductible)	
Outpatient surgery (waived if admitted)	$150 copay (after deductible)	30% coinsurance (after deductible)	
Lab tests and X-rays (diagnostic)	$25 copay	30% coinsurance (after deductible)	
Inpatient hospital care			
Inpatient care	20% coinsurance (after deductible)	30% coinsurance (after deductible)	
Maternity coverage			
Inpatient care	20% coinsurance (after deductible)	30% coinsurance (after deductible)	
Prenatal	No charge	No charge	
First postpartum visit	No charge	No charge	
Emergency and urgent care			
Emergency Department visit	$100 copay (after deductible)[2]	30% coinsurance (after deductible)	
Urgent care visit	$45 copay	$50 copay	
Ambulance service	$75 copay (after deductible)	30% coinsurance (after deductible)	
Prescription drugs			
Pharmacy (up to a 30-day supply)	$15 copay or 50% coinsurance (whichever is greater)	$15 copay or 50% coinsurance (whichever is greater)	
Other			
Vision exam	$25 copay	30% coinsurance	
Vision hardware allowance (applies to lenses, frames, and/or contacts every 24 months)	$100 allowance	Not covered	
Dental plans	Optional coverage available. See the dental brochure.		

[1]Waived if in conjunction with an office visit
[2]Waived if admitted

SILVER PLANS			BRONZE PLANS			
KP 3500/ 30/Rx	KP 5000/ 30/Rx	KP 7500/ 30/Rx	KP 2500/ 35/NM	KP 3500/ 35/NM	KP 5000/ 35/NM	KP 7500/ 35/NM
$3,500/$10,500	$5,000/$15,000	$7,500/$22,500	$2,500/$7,500	$3,500/$10,500	$5,000/$15,000	$7,500/$22,500
$7,500/$22,500			$10,000/$30,000			
Services not subject to deductible unless otherwise indicated						
Preventive care						
No charge			No charge			
No charge			No charge			
No charge			No charge			
No charge			No charge			
No charge			No charge			
No charge			No charge			
Outpatient services (per visit or procedure)						
$30 copay			$35 copay			
30% coinsurance (after deductible)			50% coinsurance (after deductible)			
30% coinsurance (after deductible)			50% coinsurance (after deductible)			
30% coinsurance (after deductible)			50% coinsurance (after deductible)			
30% coinsurance (after deductible)			50% coinsurance (after deductible)			
Inpatient hospital care						
30% coinsurance (after deductible)			50% coinsurance (after deductible)			
Maternity coverage						
30% coinsurance (after deductible)			Not covered			
No charge			No charge			
No charge			Not covered			
Emergency and urgent care						
30% coinsurance (after deductible)			50% coinsurance (after deductible)			
$50 copay			$55 copay			
30% coinsurance (after deductible)			50% coinsurance (after deductible)			
Prescription drugs						
$15 copay or 50% coinsurance (whichever is greater)			Not covered			
Other						
30% coinsurance			50% coinsurance			
Not covered			Not covered			
Optional coverage available. See the dental brochure.						

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