

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

Added Choice Contact Center: 1-866-616-0047

KP OR Gold 500/35 3T POS w/ VX - OOA

2021 Contract

| | | |
|----------------------------|-------------------------|--|
| Tier 1 Select Providers | Tier 2 PPO Providers | Tier 3 Non-Participating Providers * |
|----------------------------|-------------------------|--|

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible

The amounts you pay for covered Services subject to the Deductible 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 Deductible in Tier 2, and do not count toward the Deductible in Tier 3. The amounts you pay for covered Services subject to the Deductible in Tier 3 only count toward the Deductible in Tier 3.

| | | | |
|---|---------|---------|---------|
| Self-only Deductible per Year (for a Family of one Member) | \$500 | \$500 | \$4,500 |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | \$500 | \$500 | \$4,500 |
| Family Deductible per Year (for an entire Family) | \$1,000 | \$1,000 | \$9,000 |

Out-of-Pocket Maximum **

| | | | |
|--|----------|----------|----------|
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | \$6,000 | \$6,000 | \$10,000 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | \$6,000 | \$6,000 | \$10,000 |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | \$12,000 | \$12,000 | \$20,000 |

Office visits

You pay

| | | | |
|---|----------------|----------------|----------------------------------|
| Routine preventive physical exam | \$0 | \$0 | 50% Coinsurance after Deductible |
| Telehealth (phone/video) | \$0 | \$0 | 50% Coinsurance after Deductible |
| Primary Care | \$35 | \$35 | 50% Coinsurance after Deductible |
| Specialty Care | \$55 | \$55 | 50% Coinsurance after Deductible |
| Naturopathic Medicine (up to 6 visits per Year) | \$55 per visit | \$55 per visit | 50% Coinsurance after Deductible |
| Urgent Care | \$60 | \$60 | 50% Coinsurance after Deductible |

| Tests (outpatient) | | You pay | |
|--|--|---|----------------------------------|
| Preventive Tests | \$0 | \$0 | 50% Coinsurance after Deductible |
| Laboratory | \$35 per department visit | \$35 per department visit | 50% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | \$35 per department visit | \$35 per department visit | 50% Coinsurance after Deductible |
| CT, MRI, PET scans | \$250 after Deductible per department visit | \$250 after Deductible per department visit | 50% Coinsurance after Deductible |
| Medications (outpatient) | | You pay | |
| Prescription drugs (up to a 30-day supply) | \$10 generic / \$20 preferred brand / \$50 non-preferred brand / 50% Coinsurance specialty | At MedImpact Pharmacy \$10 generic/\$20 preferred brand/\$50 non-preferred brand/50% Coinsurance for specialty drugs | |
| Mail Order Prescription drugs (up to a 90-day supply) | \$20 generic / \$40 preferred brand / \$100 non-preferred brand | MedImpact Mail-Order call CVS Caremark 1-800-237-2767 | |
| Administered medications, including injections (all outpatient settings) | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Nurse treatment room visits to receive injections | \$10 | \$10 | 50% Coinsurance after Deductible |
| Maternity Care | | You pay | |
| Scheduled prenatal care visits and postpartum visit | \$0 | \$0 | 50% Coinsurance after Deductible |
| Laboratory | \$35 per department visit | \$35 per department visit | 50% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | \$35 per department visit | \$35 per department visit | 50% Coinsurance after Deductible |
| Inpatient Hospital Services | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Hospital Services | | You pay | |
| Ambulance Services (per transport) | 35% Coinsurance after Deductible | | |
| Emergency services | 35% Coinsurance after Deductible | | |
| Inpatient Hospital Services | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Outpatient Services (other) | | You pay | |
| Outpatient surgery visit | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Chemotherapy/radiation therapy visit | \$55 | \$55 | 50% Coinsurance after Deductible |
| Durable medical equipment | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Physical, speech, and occupational therapies (30 visits per therapy/combined per Year) | \$55 | \$55 | 50% Coinsurance after Deductible |
| Skilled Nursing Facility Services | | You pay | |
| Inpatient skilled nursing Services (up to 60 days per Year) | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | 50% Coinsurance after Deductible |

| Chemical Dependency Services | | You pay | |
|--|--|----------------------------------|----------------------------------|
| Outpatient Services | \$35 per visit | \$35 per visit | 50% Coinsurance after Deductible |
| Inpatient hospital & residential Services | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Mental Health Services | | You pay | |
| Outpatient Services | \$35 per visit | \$35 per visit | 50% Coinsurance after Deductible |
| Inpatient hospital & residential Services | 35% Coinsurance after Deductible | 35% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Alternative Care (self-referred) | | You pay | |
| Benefit Maximum per Year | Not applicable | | |
| Acupuncture Services | Not covered | Not covered | Not covered |
| Chiropractic Services | Not covered | Not covered | Not covered |
| Massage Therapy | Not covered | Not covered | Not covered |
| Vision Services | | You pay | |
| Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.) | \$0 | \$0 | 50% Coinsurance after Deductible |
| Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.) | No charge for one pair standard frames and lenses or 6-month supply contact lenses per year. | | 50% Coinsurance after Deductible |
| Routine eye exam (For members 19 years and older.) | \$35 | \$35 | 50% Coinsurance after Deductible |
| Vision hardware and optical Services (For members 19 years and older.) | Initial allowance of up to \$200 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once in a two-Year period. | | |

* Tier 3 may be subject to balance billing.

** Refer to your Evidence of Coverage (EOC) for benefits that may not apply to 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 condensed summary of benefits 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.