

# 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

Member Services: 1-800-813-2000

## KP OR Platinum 250/20 w/ ALTC

**2021 Contract**

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

### Deductible

|   |       |
|---|-------|
| Self-only Deductible per Year (for a Family of one Member)  | \$250 |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | \$250 |
| Family Deductible per Year (for an entire Family)   | \$500 |

### Out-of-Pocket Maximum \*

|  |         |
|--|---------|
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)  | \$2,500 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | \$2,500 |
| Family Out-of-Pocket Maximum per Year (for an entire Family)   | \$5,000 |

### Office visits

#### You pay

|   |                |
|---|----------------|
| Routine preventive physical exam                | \$0            |
| Telehealth (phone/video)                        | \$0            |
| Primary Care                                    | \$20           |
| Specialty Care                                  | \$30           |
| Naturopathic Medicine (up to 6 visits per Year) | \$30 per visit |
| Urgent Care                                     | \$40           |

### Tests (outpatient)

#### You pay

|   |                                  |
|---|----------------------------------|
| Preventive Tests                                  | \$0                              |
| Laboratory  | \$20 per department visit        |
| X-ray, imaging, and special diagnostic procedures | \$20 per department visit        |
| CT, MRI, PET scans                                | 10% Coinsurance after Deductible |

### Medications (outpatient)

#### You pay

|  |   |
|--|---|
| Prescription drugs (up to a 30-day supply)                               | \$5 generic / \$15 preferred brand / \$50 non-preferred brand / 50% Coinsurance specialty |
| Mail Order Prescription drugs (up to a 90-day supply)                    | \$10 generic / \$30 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  |

### Maternity Care

#### You pay

|  |                                  |
|--|----------------------------------|
| Scheduled prenatal care visits and postpartum visits | \$0                              |
| Laboratory   | \$20 per department visit        |
| X-ray, imaging, and special diagnostic procedures    | \$20 per department visit        |
| Inpatient Hospital Services                          | 10% Coinsurance after Deductible |

| <b>Hospital Services</b>   | <b>You pay</b>   |
|--|--|
| Ambulance Services (per transport)   | 10% Coinsurance after Deductible   |
| Emergency services   | 10% Coinsurance after Deductible   |
| Inpatient Hospital Services  | 10% Coinsurance after Deductible   |
| <b>Outpatient Services (other)</b>   | <b>You pay</b>   |
| Outpatient surgery visit   | 10% Coinsurance after Deductible   |
| Chemotherapy/radiation therapy visit   | \$30   |
| Durable medical equipment  | 10% Coinsurance after Deductible   |
| Physical, speech, and occupational therapies (30 visits per therapy/combined per Year)                           | \$30   |
| <b>Skilled Nursing Facility Services</b>   | <b>You pay</b>   |
| Inpatient skilled nursing Services (up to 60 days per Year)  | 10% Coinsurance after Deductible   |
| <b>Chemical Dependency Services</b>  | <b>You pay</b>   |
| Outpatient Services  | \$20 per visit   |
| Inpatient hospital & residential Services  | 10% Coinsurance after Deductible   |
| <b>Mental Health Services</b>  | <b>You pay</b>   |
| Outpatient Services  | \$20 per visit   |
| Inpatient hospital & residential Services  | 10% Coinsurance after Deductible   |
| <b>Alternative Care (self-referred)</b>  | <b>You pay</b>   |
| Benefit Maximum per Year (all alternative care services below combined)  | \$1,000  |
| Acupuncture Services   | \$20   |
| Chiropractic Services  | \$20   |
| Massage Therapy (up to 12 visits per Year)   | \$25   |
| <b>Vision Services</b>   | <b>You pay</b>   |
| Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)                     | \$0  |
| 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. |
| Routine eye exam (For members 19 years and older.)   | Not covered  |
| Vision hardware and optical Services (For members 19 years and older.)   | Not covered  |

\*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.