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 Platinum 250/20 3T POS w VX & ALTC

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)	$250	$500	$750
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$250	$500	$750
Family Deductible per Year (for an entire Family)	$500	$1,000	$1,500
Out-of-Pocket Maximum **			
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$2,500	$3,500	$7,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$2,500	$3,500	$7,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$5,000	$7,000	$14,000
Office visits		**You pay**	
Routine preventive physical exam	$0	$0	35% Coinsurance after Deductible
Telehealth (phone/video)	$0	$0	35% Coinsurance after Deductible
Primary Care	$20	$30	35% Coinsurance after Deductible
Specialty Care	$30	$40	35% Coinsurance after Deductible
Naturopathic Medicine (up to 6 visits per Year)	$30 per visit	$40 per visit	35% Coinsurance after Deductible
Urgent Care	$40	$60	35% Coinsurance after Deductible

Tests (outpatient)		**You pay**	
Preventive Tests	$0	$0	35% Coinsurance after Deductible
Laboratory	$20 per department visit	$30 per department visit	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	$30 per department visit	35% Coinsurance after Deductible
CT, MRI, PET scans	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% 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 $15 generic / $30 preferred brand / 50% coinsurance non-preferred brand / 50% coinsurance specialty	
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)	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10	$20	35% Coinsurance after Deductible
Maternity Care		**You pay**	
Scheduled prenatal care visits and postpartum visit	$0	$0	35% Coinsurance after Deductible
Laboratory	$20 per department visit	$30 per department visit	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	$30 per department visit	35% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Hospital Services		**You pay**	
Ambulance Services (per transport)	10% Coinsurance after Deductible		
Emergency services	10% Coinsurance after Deductible		
Inpatient Hospital Services	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Outpatient Services (other)		**You pay**	
Outpatient surgery visit	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$30	$40	35% Coinsurance after Deductible
Durable medical equipment	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Physical, speech, and occupational therapies (30 visits per therapy/combined per Year)	$30	$40	35% Coinsurance after Deductible

Skilled Nursing Facility Services		**You pay**	
Inpatient skilled nursing Services (up to 60 days per Year)	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Chemical Dependency Services		**You pay**	
Outpatient Services	$20 per visit	$30 per visit	35% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Mental Health Services		**You pay**	
Outpatient Services	$20 per visit	$30 per visit	35% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Alternative Care (self-referred)		**You pay**	
Benefit Maximum per Year (all alternative care services below combined)	$1,000		
Acupuncture Services	$20	$20	$20
Chiropractic Services	$20	$20	$20
Massage Therapy (up to 12 visits per Year)	$25	$25	$25
Vision Services		**You pay**	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0	$0	35% 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.)	$20	$30	35% 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.