

Summary of Medical Benefits

KP OR Silver 2800/25% H.S.A. w/ VX

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)	\$2,800
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$2,800
Family Deductible per Year (for an entire Family)	\$5,600

Out-of-Pocket Maximum *

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$5,400
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$5,400
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$10,800

Office visits

	You pay
Routine preventive physical exam	\$0
Telehealth (phone/video)	\$0 after Deductible
Primary Care	25% Coinsurance after Deductible
Specialty Care	25% Coinsurance after Deductible
Naturopathic Medicine (up to 6 visits per Year)	25% Coinsurance after Deductible
Urgent Care	25% Coinsurance after Deductible

Tests (outpatient)

	You pay
Preventive Tests	\$0
Laboratory	25% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	25% Coinsurance after Deductible
CT, MRI, PET scans	25% Coinsurance after Deductible

Medications (outpatient)

	You pay
Prescription drugs (up to a 30-day supply)	After Deductible: \$20 generic / \$40 preferred brand / 30% Coinsurance non-preferred brand / 50% Coinsurance specialty
Mail Order Prescription drugs (up to a 90-day supply)	After Deductible: \$40 generic / \$80 preferred brand / 30% Coinsurance non-preferred brand
Administered medications, including injections (all outpatient settings)	25% Coinsurance after Deductible
Nurse treatment room visits to receive injections	25% Coinsurance after Deductible

Maternity Care

	You pay
Scheduled prenatal care visits and postpartum visits	\$0
Laboratory	25% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	25% Coinsurance after Deductible
Inpatient Hospital Services	25% Coinsurance after Deductible

Hospital Services	You pay
Ambulance Services (per transport)	25% Coinsurance after Deductible
Emergency services	25% Coinsurance after Deductible
Inpatient Hospital Services	25% Coinsurance after Deductible
Outpatient Services (other)	You pay
Outpatient surgery visit	25% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	25% Coinsurance after Deductible
Durable medical equipment	25% Coinsurance after Deductible
Physical, speech, and occupational therapies (30 visits per therapy/combined per Year)	25% Coinsurance after Deductible
Skilled Nursing Facility Services	You pay
Inpatient skilled nursing Services (up to 60 days per Year)	25% Coinsurance after Deductible
Chemical Dependency Services	You pay
Outpatient Services	25% Coinsurance after Deductible
Inpatient hospital & residential Services	25% Coinsurance after Deductible
Mental Health Services	You pay
Outpatient Services	25% Coinsurance after Deductible
Inpatient hospital & residential Services	25% Coinsurance after Deductible
Alternative Care (self-referred)	You pay
Benefit Maximum per Year	Not applicable
Acupuncture Services	Not covered
Chiropractic Services	Not covered
Massage Therapy	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
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.)	25% 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.

*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.