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

Customer Service: 1-866-616-0047

Oregon **1/1/2022 - 12/31/2022**

PPO PLAN H 3000/30%/30%/7000

	In-Network Provider	Out-of-Network Provider [1]
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.		
Deductible		
Cost Share amounts that count toward the Deductible are shown below. The In-Network Deductible and the Out-of-Network Deductible do not cross accumulate. This means that the amounts you pay for covered Services received from In-Network Providers only count toward the In-Network Deductible, and the amounts you pay for covered Services received from Out-of-Network Providers only count toward the Out-of-Network Deductible.		
Self-only Deductible per Year (for a Family of one Member)	$3,000	$5,000
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$3,000	$5,000
Family Deductible per Year (for an entire Family)	$6,000	$15,000
Out-of-Pocket Maximum [2]		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$7,000	$15,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$7,000	$15,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$14,000	$30,000
Office Visits	**You pay**	
Routine preventive physical exam	$0	50% Coinsurance after Deductible
Telehealth (phone/video)	$0	50% Coinsurance after Deductible
Primary Care	40% Coinsurance after Deductible Enhanced Benefit [3]: 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Specialty Care	40% Coinsurance after Deductible Enhanced Benefit [3]: 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible Enhanced Benefit [3]: 30% Coinsurance after Deductible	50% Coinsurance after Deductible

Tests (outpatient)	**You pay**	
Preventive Tests	$0	50% Coinsurance after Deductible
Laboratory	30% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	30% Coinsurance after Deductible	50% Coinsurance after Deductible
CT, MRI, PET scans	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Medications (outpatient)	**You pay**	
Prescription drugs (up to a 30 day supply)	Kaiser Permanente Pharmacy: Not Covered MedImpact Pharmacy: Not Covered	
Mail Order Prescription drugs (up to a 90 day supply)	Kaiser Permanente Pharmacy: Not Covered MedImpact: call CVS Caremark 1-800-237-2767	
Administered medications, including injections (all outpatient settings)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10	50% Coinsurance after Deductible
Maternity Care	**You pay**	
Scheduled prenatal care visits and postpartum visit	$0	50% Coinsurance after Deductible
Laboratory	30% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Hospital Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospital Services	**You pay**	
Ambulance Services (per transport)	20% Coinsurance	
Emergency services	$200 after Deductible (Waived if admitted)	
Inpatient Hospital Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Services (other)	**You pay**	
Outpatient surgery visit	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	40% Coinsurance after Deductible Enhanced Benefit [3]: 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Durable medical equipment	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	40% Coinsurance after Deductible Enhanced Benefit [3]: 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility Services	**You pay**	
Inpatient skilled nursing Services (up to 100 days per Year)	30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Mental Health and Chemical Dependency Services	**You pay**	
Outpatient Services	40% Coinsurance after Deductible Enhanced Benefit [3]: 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient hospital & residential Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**	
Acupuncture Services	Not Covered	Not Covered
Chiropractic Services	Not Covered	Not Covered
Massage Therapy	Not Covered	Not Covered
Naturopathic Medicine	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Vision Services	**You pay**	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	40% Coinsurance after Deductible Enhanced Benefit [3]: 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	Not Covered	Not covered
Routine eye exam (For members 19 years and older.)	40% Coinsurance after Deductible Enhanced Benefit [3]: 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Vision hardware and optical Services (For members 19 years and older.)	Not Covered	

[1] Out-of-Network Providers may bill you for any charges in excess of the Allowed Amount (balance billing).

[2] Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

[3] You pay the lowest Cost Share when you receive certain covered Services from a select group of In-Network Providers. This is called “Enhanced Benefits.” Enhanced Benefits are shown in this summary. In-Network Providers who offer Enhanced Benefits are identified with an asterisk (*) in the provider directory. Visit **kp.org/dualchoice/nw** for a searchable provider directory.

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 Customer Service 1-866-616-0047 (M-F, 8 am-6 pm) or visit **kp.org**

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 Customer Service. In the case of a conflict between this summary and the EOC, the EOC will prevail.

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