

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

Oregon TRAD PLAN C 20/2000

1/1/2023 - 12/31/2023

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)	None
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	None
Family Deductible per Year (for an entire Family)	None

Out-of-Pocket Maximum ¹

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$2,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$2,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$4,000

Office Visits

You pay

Routine preventive physical exam	\$0
Telehealth (phone/video)	\$0
Primary Care	\$20
Specialty Care	\$30
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	\$50 per department visit

Medications (outpatient)

You pay

Prescription drugs (up to a 30 day supply)	Not Covered
Mail Order Prescription drugs (up to a 90 day supply)	Not Covered
Administered medications, including injections (all outpatient settings)	20% Coinsurance
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	\$200 per day up to \$1,000 per admission

Hospital Services	You pay
Ambulance Services (per transport)	\$75
Emergency services	\$200 (Waived if admitted)
Inpatient Hospital Services	\$200 per day up to \$1,000 per admission
Outpatient Services (other)	You pay
Outpatient surgery visit	\$50
Chemotherapy/radiation therapy visit	\$30
Durable medical equipment	20% Coinsurance
Physical, speech, and occupational therapies (20 visits per therapy per Year)	\$30
Skilled Nursing Facility Services	You pay
Inpatient skilled nursing Services (up to 100 days per Year)	\$0
Mental Health and Substance Use Disorder Services	You pay
Outpatient Services	\$20 per visit
Inpatient hospital & residential Services	\$200 per day up to \$1,000 per admission
Alternative Care (self-referred)	You pay
Acupuncture Services	Not Covered
Chiropractic Services	Not Covered
Massage Therapy	Not Covered
Naturopathic Medicine	\$20
Vision Services	You pay
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	\$20
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	Not Covered
Routine eye exam (For members 19 years and older.)	\$20
Vision hardware and optical Services (For members 19 years and older.)	Not Covered

¹ 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, all areas: 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.