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 KP PLUS PLAN C 750/20/20%/3000 **1/1/2023 - 12/31/2023**

	In-Network	Out-of-Network
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.		
Deductible Services that are subject to the Deductible are indicated below. After you meet your Deductible, you pay the Cost Share amount shown in this summary.		
Self-only Deductible per Year (for a Family of one Member)	$750	Not applicable
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$750	Not applicable
Family Deductible per Year (for an entire Family)	$2,250	Not applicable
Out-of-Pocket Maximum [2]		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$3,000	Not applicable
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$3,000	Not applicable
Family Out-of-Pocket Maximum per Year (for an entire Family)	$9,000	Not applicable

	In-Network	Out-of-Network [1] (Limited to 10 covered Services per Year, combined)
When you receive covered Services from Participating Providers, you pay the In-Network Cost Share shown below. When you receive covered Services from Non-Participating Providers, you pay the Out-of-Network Cost Share shown below.		
Office Visits	**You pay**	
Routine preventive physical exam	$0	$0
Telehealth (phone/video)	$0	Cost Share applicable to the Service when provided in person
Primary Care	$20	$40
Specialty Care	$20	$40
Urgent Care	$20	Not covered, except for Services received outside the Service Area [3]

Tests (outpatient)	**You pay**	
Preventive Tests	$0	$0
Laboratory	20% Coinsurance after Deductible	30% Coinsurance
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible	30% Coinsurance
CT, MRI, PET scans	20% Coinsurance after Deductible	Not covered
Medications (outpatient)	**You pay**	
Prescription drugs (up to a 30-day supply)	Covered based on Rider purchased	Covered based on Rider purchased (Limited to 5 prescription fills per Year) [3]
Mail Order Prescription drugs (up to a 90-day supply)	Covered based on Rider purchased	Not covered
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible	Not covered
Nurse treatment room visits to receive injections	$10	$30
Maternity Care	**You pay**	
Scheduled prenatal care visits and postpartum visit	$0	$0
Laboratory	20% Coinsurance after Deductible	30% Coinsurance
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible	30% Coinsurance
Inpatient Hospital Services	20% Coinsurance after Deductible	Not covered
Hospital Services	**You pay**	
Ambulance Services (per transport)	20% Coinsurance after Deductible	Covered In-Network [3]
Emergency services	$200 after Deductible (Waived if admitted)	Covered In-Network [3]
Inpatient Hospital Services	20% Coinsurance after Deductible	Not covered
Outpatient Services (other)	**You pay**	
Outpatient surgery visit	20% Coinsurance after Deductible	Not covered
Chemotherapy/radiation therapy visit	$20 after Deductible	Not covered
Durable medical equipment	20% Coinsurance after Deductible	Not covered
Physical, speech, and occupational therapies (20 visits per therapy per Year)	$20	$40
Skilled Nursing Facility Services	**You pay**	
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible	Not covered
Mental Health and Substance Use Disorder Services	**You pay**	
Outpatient Services	$20 per visit	$40 per visit
Inpatient hospital & residential Services	20% Coinsurance after Deductible	Not covered

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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	$20	$40
Vision Services	**You pay**	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$20	$40
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.)	$20	$40
Vision hardware and optical Services (For members 19 years and older.)	Not covered	Not covered

[1] Non-participating providers may bill you for any charges in excess of the Allowed Amount (balance billing), except where balance billing is prohibited by law. You are protected from balance billing in connection with emergency services and certain services provided at a participating hospital or ambulatory surgical center. For additional information, visit **https://healthy.kaiserpermanente.org/oregon-washington/support/pay-bills/medical-bills/no-surprises-act.**

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

[3] The 10 covered Services limit does not apply.

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 **kp.org/plandocuments**.

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

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

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