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 DED PLAN K 5000/30/20%/7350

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.

Self-only Deductible per Year (for a Family of one Member) \$5,000 Individual Family Member Deductible per Year (for each \$5,000 Member in a Family of two or more Members) \$10,000 Cut-of-Pocket Maximum ¹ \$10,000 Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) \$7,350 Individual Family Member Out-of-Pocket Maximum per Year (for a entire for each Member in a Family of two or more Members) \$7,350 Family Out-of-Pocket Maximum per Year (for a entire feamily) \$14,700 Family Out-of-Pocket Maximum per Year (for a entire feamily) \$14,700 Family Cut-of-Pocket Maximum per Year (for a entire feamily) \$14,700 Family Cut-of-Pocket Maximum per Year (for a entire feamily) \$14,700 Family Cut-of-Pocket Maximum per Year (for a entire feamily) \$14,700 Family Cut-of-Pocket Maximum per Year (for a entire feamily) \$14,700 Family Care \$30 Specialty Care \$40 Urgent Care \$50 Tests (outpatient) You pay Preventive Tests \$00 Laboratory \$30 per department visit X-ray, imaging, and special diagnostic procedures \$30 per department visit <	Deductible	
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	Laboratory	\$30 per department visit
Inpatient Hospital Services 20% Coinsurance after Deductible	X-ray, imaging, and special diagnostic procedures	\$30 per department visit
	Inpatient Hospital Services	20% Coinsurance after Deductible

Hospital Services	You pay
Ambulance Services (per transport)	20% Coinsurance
Emergency services	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	You pay
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	\$40 after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	\$40
Skilled Nursing Facility Services	You pay
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	You pay
Outpatient Services	\$30 per visit
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care (self-referred)	You pay
Acupuncture Services	Not Covered
Chiropractic Services	Not Covered
Massage Therapy	Not Covered
Naturopathic Medicine	\$30
Vision Services	You pay
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	\$30
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.)	\$30
Vision hardware and optical Services (For members 19 years and older.)	Not Covered

¹Refer 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.

