

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 2C20

1/1/2020 - 12/31/2020

Harrison Electrical Workers Trust Fund

Group Number: 2454-014

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)	\$500
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$500
Family Deductible per Year (for an entire Family)	\$1,500

Out-of-Pocket Maximum *

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$6,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$6,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$12,000

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	\$100 per department visit

Medications (outpatient)

You pay

Prescription drugs (up to a 30 day supply)	\$15 generic / \$30 preferred brand / \$50 non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	\$30 generic / \$60 preferred brand / \$100 non-preferred brand
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible
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

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Inpatient Hospital Services	20% Coinsurance after Deductible
Hospital Services	You pay
Ambulance Services (per transport)	20% Coinsurance after Deductible
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	\$30 after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)	\$30
Skilled Nursing Facility Services	You pay
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible
Chemical Dependency Services	You pay
Outpatient Services	\$20 per visit
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	You pay
Outpatient Services	\$20 per visit
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care (self referred) **	You pay
Benefit Maximum per Year (not applicable)	Not Applicable
Acupuncture Services	Not Covered
Chiropractic Services	Not Covered
Massage Therapy	Not Covered
Naturopathic Medicine	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 eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)	\$20
Vision hardware and optical Services (For members 19 years and older.)	Initial allowance of up to \$150 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.

** Refer to your Evidence of Coverage (EOC) for any applicable visits limits for self referred Alternative Care services.

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.