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 HDHP Plan $5,000/50%/ **4/1/2021 - 3/31/2022**

Multnomah Bar Association **Group Number: 1568-187**

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)	$5,000
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$5,000
Family Deductible per Year (for an entire Family)	$10,000
Out-of-Pocket Maximum *	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$6,750
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$6,750
Family Out-of-Pocket Maximum per Year (for an entire Family)	$13,500
Office visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0 after Deductible
Primary Care	50% Coinsurance after Deductible
Specialty Care	50% Coinsurance after Deductible
Urgent Care	50% Coinsurance after Deductible
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	50% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	50% Coinsurance after Deductible
CT, MRI, PET scans	50% Coinsurance after Deductible
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	After Deductible: $15 generic / $30 preferred brand / $50 non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	After Deductible: $30 generic / $60 preferred brand / $100 non-preferred brand
Administered medications, including injections (all outpatient settings)	50% Coinsurance after Deductible
Nurse treatment room visits to receive injections	50% Coinsurance after Deductible
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	50% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	50% Coinsurance after Deductible

Inpatient Hospital Services	50% Coinsurance after Deductible
Hospital Services	**You pay**
Ambulance Services (per transport)	50% Coinsurance after Deductible
Emergency services	50% Coinsurance after Deductible
Inpatient Hospital Services	50% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	50% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	50% Coinsurance after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	50% Coinsurance after Deductible
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	50% Coinsurance after Deductible
Chemical Dependency Services	**You pay**
Outpatient Services	50% Coinsurance after Deductible
Inpatient hospital & residential Services	50% Coinsurance after Deductible
Mental Health Services	**You pay**
Outpatient Services	50% Coinsurance after Deductible
Inpatient hospital & residential Services	50% Coinsurance after Deductible
Alternative Care (self referred) **	**You pay**
Benefit Maximum per Year ()	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.)	50% Coinsurance after Deductible
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.