

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 C20D

4/1/2020 - 3/31/2021

Lewis & Clark College **HMO Plan**

Group Number: 1495-001

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) | \$0 |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | \$0 |
| Family Deductible per Year (for an entire Family) | \$0 |

Out-of-Pocket Maximum *

| | |
|--|---------|
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | \$1,250 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | \$1,250 |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | \$2,500 |

Office visits

You pay

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|----------------------------------|------|
| Routine preventive physical exam | \$0 |
| Telehealth (phone/video) | \$0 |
| Primary Care | \$15 |
| Specialty Care | \$15 |
| Urgent Care | \$35 |

Tests (outpatient)

You pay

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|---|--------------------------|
| Preventive Tests | \$0 |
| Laboratory | \$0 |
| X-ray, imaging, and special diagnostic procedures | \$0 |
| CT, MRI, PET scans | \$0 per department visit |

Medications (outpatient)

You pay

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|--|---|
| 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 |
| Nurse treatment room visits to receive injections | \$5 |

Maternity Care

You pay

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|--|---------------------|
| Scheduled prenatal care visits and postpartum visits | \$0 |
| Laboratory | \$0 |
| X-ray, imaging, and special diagnostic procedures | \$0 |
| Inpatient Hospital Services | \$250 per admission |

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| Hospital Services | You pay |
| Ambulance Services (per transport) | \$75 |
| Emergency services | \$75 (Waived if admitted) |
| Inpatient Hospital Services | \$250 per admission |
| Outpatient Services (other) | You pay |
| Outpatient surgery visit | \$15 |
| Chemotherapy/radiation therapy visit | \$15 |
| Durable medical equipment | 20% Coinsurance |
| Physical, speech, and occupational therapies (up to 20 visits per therapy per Year) | \$15 |
| Skilled Nursing Facility Services | You pay |
| Inpatient skilled nursing Services (up to 100 days per Year) | \$0 |
| Chemical Dependency Services | You pay |
| Outpatient Services | \$15 per visit |
| Inpatient hospital & residential Services | \$250 per admission |
| Mental Health Services | You pay |
| Outpatient Services | \$15 per visit |
| Inpatient hospital & residential Services | \$250 per admission |
| Alternative Care (self referred) ** | You pay |
| Benefit Maximum per Year (all Covered Services combined) | \$1,500 |
| Acupuncture Services | \$15 per visit |
| Chiropractic Services | \$15 per visit |
| Massage Therapy (up to 12 visits per Year) | \$25 per visit |
| Naturopathic Medicine | \$15 per visit |
| 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.) | \$15 |
| 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.

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