

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 FA13

4/1/2023 - 3/31/2024

Lewis & Clark College

Group Number: 1495-020

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)	\$1,500
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$3,000
Family Deductible per Year (for an entire Family)	\$3,000

Out-of-Pocket Maximum ¹

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$2,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$5,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$5,000

Office Visits

You pay

Routine preventive physical exam	\$0
Telehealth (phone/video)	\$0 after Deductible
Primary Care	10% Coinsurance after Deductible
Specialty Care	10% Coinsurance after Deductible
Urgent Care	10% Coinsurance after Deductible

Tests (outpatient)

You pay

Preventive Tests	\$0
Laboratory	10% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible
CT, MRI, PET scans	10% 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 / \$150 specialty
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)	10% Coinsurance after Deductible
Nurse treatment room visits to receive injections	10% Coinsurance after Deductible

Maternity Care

You pay

Scheduled prenatal care visits and postpartum visits	\$0
Laboratory	10% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible

Hospital Services

You pay

Ambulance Services (per transport)	10% Coinsurance after Deductible
Emergency services	10% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible

Outpatient Services (other)	You pay
Outpatient surgery visit	10% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	10% Coinsurance after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	10% Coinsurance after Deductible
Skilled Nursing Facility Services	You pay
Inpatient skilled nursing Services (up to 100 days per Year)	10% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	You pay
Outpatient Services	10% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible
Alternative Care (self-referred)	You pay
Acupuncture Services (up to 12 visits per Year)	\$25 per visit after Deductible
Chiropractic Services (up to 20 visits per Year)	\$25 per visit after Deductible
Massage Therapy (up to 12 visits per Year)	\$25 per visit after Deductible
Naturopathic Medicine	10% Coinsurance after Deductible
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.)	10% 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.

¹ Refer 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 **kp.org/plandocuments**.

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>.

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.