

# 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

Oregon DED PLAN B 500/20/10%/3000

1/1/2025 - 12/31/2025

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 <sup>1</sup>

|                                                                                                              |         |
|--------------------------------------------------------------------------------------------------------------|---------|
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)                                        | \$3,000 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | \$3,000 |
| Family Out-of-Pocket Maximum per Year (for an entire Family)                                                 | \$6,000 |

## Office Visits

### You pay

|                                  |                                                                                |
|----------------------------------|--------------------------------------------------------------------------------|
| Routine preventive physical exam | \$0                                                                            |
| Telehealth (phone/video)         | \$0 *                                                                          |
| Primary Care                     | \$5 for the first 3 visits; then \$20 for additional visits in the same Year * |
| 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)                               | Rider Available for Purchase     |
| Mail Order Prescription drugs (up to a 90-day supply)                    |                                  |
| Administered medications, including injections (all outpatient settings) | 10% 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        |
| Inpatient Hospital Services                          | 10% Coinsurance after Deductible |

|                                                                                                                  |                                                                                          |
|------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <b>Hospital Services</b>                                                                                         | <b>You pay</b>                                                                           |
| Ambulance Services (per transport)                                                                               | 10% Coinsurance after Deductible                                                         |
| Emergency services                                                                                               | 10% Coinsurance after Deductible                                                         |
| Inpatient Hospital Services                                                                                      | 10% Coinsurance after Deductible                                                         |
| <b>Outpatient Services (other)</b>                                                                               | <b>You pay</b>                                                                           |
| Outpatient surgery visit                                                                                         | 10% Coinsurance after Deductible                                                         |
| Chemotherapy/radiation therapy visit                                                                             | \$30 after Deductible                                                                    |
| Durable medical equipment                                                                                        | 10% Coinsurance after Deductible                                                         |
| Physical, speech, and occupational therapies (20 visits per therapy per Year)                                    | \$30                                                                                     |
| <b>Skilled Nursing Facility Services</b>                                                                         | <b>You pay</b>                                                                           |
| Inpatient skilled nursing Services (up to 100 days per Year)                                                     | 10% Coinsurance after Deductible                                                         |
| <b>Mental Health and Substance Use Disorder Services</b>                                                         | <b>You pay</b>                                                                           |
| Outpatient Services                                                                                              | \$5 for the first 3 visits; then \$20 per visit for additional visits in the same Year * |
| Inpatient hospital & residential Services                                                                        | 10% Coinsurance after Deductible                                                         |
| <b>Alternative Care (self-referred)</b>                                                                          | <b>You pay</b>                                                                           |
| Acupuncture Services                                                                                             | Rider Available for Purchase                                                             |
| Chiropractic Services                                                                                            |                                                                                          |
| Massage Therapy                                                                                                  |                                                                                          |
| Naturopathic Medicine                                                                                            | \$5 for the first 3 visits; then \$20 for additional visits in the same Year *           |
| <b>Vision Services</b>                                                                                           | <b>You pay</b>                                                                           |
| Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)                     | \$20                                                                                     |
| Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.) | Rider Available for Purchase                                                             |
| Routine eye exam (For members 19 years and older.)                                                               | \$20                                                                                     |
| Vision hardware and optical Services (For members 19 years and older.)                                           | Rider Available for Purchase                                                             |

<sup>1</sup> Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

\* First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, mental health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient 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 **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.