

# 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 - Custom Deductible Plan**

**1/1/2024 - 12/31/2024**

**SAIF Corporation**

**Group Number: 1816-020**

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)	\$1,350
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$1,350
Family Deductible per Year (for an entire Family)	\$4,050

## Out-of-Pocket Maximum <sup>1</sup>

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$3,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$3,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$10,500

## Office Visits

	You pay
Routine preventive physical exam	\$0
Telehealth (phone/video)	\$0 *
Primary Care	\$5 for first 3 visits; then \$25 for additional visits in the same Year *
Specialty Care	\$35
Urgent Care	\$35

## Tests (outpatient)

	You pay
Preventive Tests	\$0
Laboratory	10% Coinsurance
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)	\$10 generic / \$30 preferred brand / 50% Coinsurance (up to \$100 max) non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	\$20 generic / \$60 preferred brand / 50% Coinsurance (up to \$200 max) non-preferred brand
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	10% Coinsurance
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible
Inpatient Hospital Services	\$100 per day up to \$500 per admission

## Hospital Services

	You pay
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Ambulance Services (per transport)	\$150
Emergency services	\$150 (Waived if admitted)
Inpatient Hospital Services	\$100 per day up to \$500 per Year
<b>Outpatient Services (other)</b>	<b>You pay</b>
Outpatient surgery visit	10% Coinsurance
Chemotherapy/radiation therapy visit	\$35
Durable medical equipment	10% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	\$35
<b>Skilled Nursing Facility Services</b>	<b>You pay</b>
Inpatient skilled nursing Services (up to 100 days per Year)	\$0 after Deductible
<b>Mental Health and Substance Use Disorder Services</b>	<b>You pay</b>
Outpatient Services	\$5 for first 3 visits; then \$25 per visit for additional visits in the same Year *
Inpatient hospital & residential Services	\$100 per day up to \$500 per year
<b>Alternative Care (self-referred)</b>	<b>You pay</b>
Acupuncture Services (up to 24 visits per Year)	\$25 per visit
Chiropractic Services (up to 30 visits per Year)	\$25 per visit
Massage Therapy (up to 12 visits per Year)	\$25 per visit
Naturopathic Medicine	\$5 for first 3 visits; then \$25 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.)	\$25
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	Not covered
Routine eye exam (For members 19 years and older.)	\$25
Vision hardware and optical Services (For members 19 years and older.)	Not covered

<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](http://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](http://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.