

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

Added Choice Contact Center: 1-866-616-0047

KP WA Gold 1000/20 3T POS w/VX

2023 Contract

Select Providers PPO Providers Non-Participating Providers¹

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible

For Services that are subject to the Deductible, the amounts you pay for covered Services from Select Providers also count toward the Deductible for Services from PPO Providers, and vice versa. The amounts you pay for Services from Non-Participating Providers only count toward the Deductible for Services from Non-Participating Providers.

Self-only Deductible per Year (for a Family of one Member)	\$1,000	\$2,000	\$6,000
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$1,000	\$2,000	\$6,000
Family Deductible per Year (for an entire Family)	\$2,000	\$4,000	\$12,000

Out-of-Pocket Maximum²

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$6,500	\$8,500	\$10,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$6,500	\$8,500	\$10,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$13,000	\$17,000	\$21,000

Office Visits

You pay

Routine preventive physical exam	\$0	\$0	50% Coinsurance after Deductible
Telehealth (phone/video)	\$0	\$0	50% Coinsurance after Deductible
Primary Care	\$20	\$40	50% Coinsurance after Deductible
Specialty Care	\$40	\$60	50% Coinsurance after Deductible
Urgent Care	\$50	\$100	50% Coinsurance after Deductible

Tests (outpatient)

You pay

Preventive Tests	\$0	\$0	50% Coinsurance after Deductible
Laboratory	\$20 per department visit	40% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	\$20 per department visit	40% Coinsurance after Deductible	50% Coinsurance after Deductible
CT, MRI, PET scans	\$300 per department visit	40% Coinsurance after Deductible	50% Coinsurance after Deductible

Medications (outpatient)		You pay	
Prescription drugs (up to a 30-day supply)	\$10 generic / \$30 preferred brand / 50% Coinsurance non-preferred brand / 50% Coinsurance specialty	At MedImpact Pharmacy \$25 generic/\$75 preferred brand/50% Coinsurance non-preferred brand/50% Coinsurance for specialty drugs	
Mail Order Prescription drugs (up to a 90day supply)	\$20 generic / \$60 preferred brand / 50% Coinsurance non-preferred brand	MedImpact Mail-Order call CVS Caremark 1-800-237-2767	
Administered medications, including injections (all outpatient settings)	25% Coinsurance	40% Coinsurance	50% Coinsurance after Deductible
Nurse treatment room visits to receive injections	\$10	\$40	50% Coinsurance after Deductible
Maternity Care		You pay	
Scheduled prenatal care visits and postpartum visit	\$0	\$0	50% Coinsurance after Deductible
Laboratory	\$20 per department visit	40% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	\$20 per department visit	40% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Hospital Services	25% Coinsurance after Deductible	40% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospital Services		You pay	
Ambulance Services (per transport)	25% Coinsurance after Deductible		
Emergency services	25% Coinsurance after Deductible		
Inpatient Hospital Services	25% Coinsurance after Deductible	40% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Services (other)		You pay	
Outpatient surgery visit	25% Coinsurance after Deductible	40% Coinsurance after Deductible	50% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	\$40	\$60	50% Coinsurance after Deductible
Durable medical equipment	25% Coinsurance after Deductible	40% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical, speech, and occupational therapies (25 visits per Year)	\$40	\$60	50% Coinsurance after Deductible
Skilled Nursing Facility Services		You pay	
Inpatient skilled nursing Services (up to 60 days per Year)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services		You pay	
Outpatient Services	\$20 per visit	\$40 per visit	50% Coinsurance after Deductible
Inpatient hospital & residential Services	25% Coinsurance after Deductible	40% Coinsurance after Deductible	50% Coinsurance after Deductible

Alternative Care (self-referred)		You pay	
Acupuncture Services (up to 12 visits per Year)	\$40 per visit	\$60 per visit	50% Coinsurance after Deductible
Chiropractic Services (up to 10 visits per Year)	\$40 per visit	\$60 per visit	50% Coinsurance after Deductible
Massage Therapy	Not covered	Not covered	Not covered
Naturopathic Medicine	\$20	\$40	50% 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	\$0	50% Coinsurance after Deductible
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	No charge for one pair standard frames and lenses or 12-month supply contact lenses per year.		50% Coinsurance after Deductible
Routine eye exam (For members 19 years and older.)	\$20	\$40	50% Coinsurance
Vision hardware and optical Services (For members 19 years and older.)	Balance after \$200 allowance in a two-Year period.		

¹ Non-Participating Providers may be subject to balance billing.

² Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

Pediatric Dental

**In-network benefit
(reimbursement is based
on MAC) ³**

**Out-of-network benefit
(reimbursement is based
on UCC) ³**

	In-network benefit (reimbursement is based on MAC) ³	Out-of-network benefit (reimbursement is based on UCC) ³
Preventive and Diagnostic Services		
	You pay	
Oral exam	\$0	\$0
X-rays	\$0	\$0
Teeth cleaning	\$0	\$0
Fluoride	\$0	\$0
Basic Restoration Services		
	You pay	
Routine fillings	50% Coinsurance	50% Coinsurance
Plastic and steel crowns	50% Coinsurance	50% Coinsurance
Simple extractions	50% Coinsurance	50% Coinsurance
Oral Surgery Services		
	You pay	
Surgical tooth extractions	50% Coinsurance	50% Coinsurance
Periodontics		
	You pay	
Treatment of gum disease	50% Coinsurance	50% Coinsurance
Scaling and root planing	50% Coinsurance	50% Coinsurance
Endodontics		
	You pay	
Root canal therapy	50% Coinsurance	50% Coinsurance
Major Restoration Services		
	You pay	
Gold or porcelain crowns	50% Coinsurance	50% Coinsurance
Bridges	50% Coinsurance	50% Coinsurance
Removable Prosthetic Services		
	You pay	
Full and partial dentures	50% Coinsurance	50% Coinsurance
Relines	50% Coinsurance	50% Coinsurance
Rebases	50% Coinsurance	50% Coinsurance
Nitrous oxide		
	You pay	
Adults and children age 13 years and older	\$25	\$25
Children age 12 years and younger	\$0	\$0
Orthodontics (medically necessary, diagnosis of cleft palate/lip)	50% Coinsurance	50% Coinsurance

³ "UCC" means Usual and Customary Charge. "MAC" means Maximum Allowable Charge. See your Evidence of Coverage (EOC) for more details.

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.

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.