

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	\$30 generic / \$50 preferred brand / 50% Coinsurance non-preferred brand / 50% Coinsurance for specialty drugs (Limited to 5 prescription fills per Year) ³
Mail Order Prescription drugs (up to a 90-day supply)	\$20 generic / \$60 preferred brand / 50% Coinsurance non-preferred brand	Not covered
Administered medications, including injections (all outpatient settings)	25% Coinsurance after Deductible	Not covered
Nurse treatment room visits to receive injections	\$10	\$30
Maternity Care		You pay
Scheduled prenatal care visits and postpartum visit	\$0	\$0
Laboratory	\$20 per department visit	\$40 per department visit
X-ray, imaging, and special diagnostic procedures	\$20 per department visit	\$40 per department visit
Inpatient Hospital Services	25% Coinsurance after Deductible	Not covered
Hospital Services		You pay
Ambulance Services (per transport)	25% Coinsurance after Deductible	Covered In-Network ³
Emergency services	25% Coinsurance after Deductible	Covered In-Network ³
Inpatient Hospital Services	25% Coinsurance after Deductible	Not covered
Outpatient Services (other)		You pay
Outpatient surgery visit	25% Coinsurance after Deductible	Not covered
Chemotherapy/radiation therapy visit	\$40	Not covered
Durable medical equipment	25% Coinsurance after Deductible	Not covered
Physical, speech, and occupational therapies (25 visits per Year)	\$40	\$60
Skilled Nursing Facility Services		You pay
Inpatient skilled nursing Services (up to 60 days per Year)	25% Coinsurance after Deductible	Not covered
Mental Health and Substance Use Disorder Services		You pay
Outpatient Services	\$20 per visit	\$40 per visit
Inpatient hospital & residential Services	25% Coinsurance after Deductible	Not covered
Alternative Care (self-referred)		You pay
Acupuncture Services (up to 12 visits per Year)	\$40 per visit	\$60 per visit
Chiropractic Services (up to 10 visits per Year)	\$40 per visit	\$60 per visit
Massage Therapy	Not covered	Not covered
Naturopathic Medicine	\$20	\$40

Vision Services	You pay	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	\$0	\$40
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.	Not covered
Routine eye exam (For members 19 years and older.)	Not covered	Not covered
Vision hardware and optical Services (For members 19 years and older.)	Not covered	Not covered

¹ 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>.

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

³ The 10 covered Services limit does not apply.

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 Customer Service at 1-866-616-0047 (M-F, 8 am-6 pm) or visit kp.org.

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 Customer Service. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Pediatric Dental (covered until the end of the month in which Member turns 19 years of age)	In-network benefit (reimbursement is based on MAC)	Out-of-network benefit (reimbursement is based on UCC) ⁴
Preventive and Diagnostic Services	You pay	
Oral exam	\$0	\$0
X-rays	\$0	\$0
Teeth cleaning	\$0	\$0
Fluoride	\$0	\$0
Minor 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 and related 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

⁴“UCC” means Usual and Customary Charge. “MAC” means Maximum Allowable Charge. See your Evidence of Coverage (EOC) for more details.

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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

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