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

Customer Service: 1-866-616-0047

KP WA Platinum 0/20 KP Plus

2023 Contract

	In-Network	Out-of-Network
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.		
Deductible Services that are subject to the Deductible are indicated below. After you meet your Deductible, you pay the Cost Share amount shown in this summary.		
Self-only Deductible per Year (for a Family of one Member)	None	Not applicable
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	None	Not applicable
Family Deductible per Year (for an entire Family)	None	Not applicable
Out-of-Pocket Maximum [2]		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$2,000	Not applicable
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$2,000	Not applicable
Family Out-of-Pocket Maximum per Year (for an entire Family)	$4,000	Not applicable

	In-Network	Out-of-Network [1] (Limited to 10 covered Services per Year, combined)
When you receive covered Services from Participating Providers, you pay the In-Network Cost Share shown below. When you receive covered Services from Non-Participating Providers, you pay the Out-of-Network Cost Share shown below.		
Office Visits	**You pay**	
Routine preventive physical exam	$0	$0
Telehealth (phone/video)	$0	Cost Share applicable to the Service when provided in person
Primary Care	$20	$40
Specialty Care	$30	$50
Urgent Care	$40	Not covered, except for Services received outside the Service Area [3]
Tests (outpatient)	**You pay**	
Preventive Tests	$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
CT, MRI, PET scans	$75 per department visit	Not covered

Medications (outpatient)	**You pay**	
Prescription drugs (up to a 30-day supply)	$5 generic / $15 preferred brand / $50 non-preferred brand / 50% Coinsurance specialty	$25 generic / $35 preferred brand / $70 non-preferred brand / 50% Coinsurance Specialty (Limited to 5 prescription fills per Year) [3]
Mail Order Prescription drugs (up to a 90-day supply)	$10 generic / $30 preferred brand / $100 non-preferred brand	Not covered
Administered medications, including injections (all outpatient settings)	20% Coinsurance	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	$300 per day up to $1,500 per admission	Not covered
Hospital Services	**You pay**	
Ambulance Services (per transport)	$150	Covered In-Network [3]
Emergency services	$150 (Waived if admitted)	Covered In-Network [3]
Inpatient Hospital Services	$300 per day up to $1,500 per admission	Not covered
Outpatient Services (other)	**You pay**	
Outpatient surgery visit	$100	Not covered
Chemotherapy/radiation therapy visit	$30	Not covered
Durable medical equipment	20% Coinsurance	Not covered
Physical, speech, and occupational therapies (25 visits per Year)	$30	$50
Skilled Nursing Facility Services	**You pay**	
Inpatient skilled nursing Services (up to 60 days per Year)	$300 per day up to $1,500 per admission	Not covered
Mental Health and Substance Use Disorder Services	**You pay**	
Outpatient Services	$20 per visit	$40 per visit
Inpatient hospital & residential Services	$300 per day up to $1,500 per admission	Not covered
Alternative Care (self-referred)	**You pay**	
Acupuncture Services (up to 12 visits per Year)	$30 per visit	$50 per visit
Chiropractic Services (up to 10 visits per Year)	$30 per visit	$50 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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