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 Platinum 250/20 PPO Plus

2023 Contract

	PPO Providers	Non-Participating Providers [1]
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 PPO Providers do not count toward the Deductible for Services from Non-Participating Providers, and vice versa.		
Self-only Deductible per Year (for a Family of one Member)	$250	$750
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$250	$750
Family Deductible per Year (for an entire Family)	$500	$1,500
Out-of-Pocket Maximum [2]		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$3,000	$7,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$3,000	$7,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$6,000	$14,000
Office Visits	**You pay**	
Routine preventive physical exam	$0	35% Coinsurance after Deductible
Telehealth (phone/video)	$0	35% Coinsurance after Deductible
Primary Care	$20	35% Coinsurance after Deductible
Specialty Care	$30	35% Coinsurance after Deductible
Urgent Care	$40	35% Coinsurance after Deductible
Tests (outpatient)	**You pay**	
Preventive Tests	$0	35% Coinsurance after Deductible
Laboratory	$20 per department visit	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	35% Coinsurance after Deductible
CT, MRI, PET scans	15% Coinsurance after Deductible	35% Coinsurance after Deductible

Medications (outpatient)	**You pay**	
Prescription drugs (up to a 30-day supply)	MedImpact Pharmacies & Kaiser Permanente Pharmacies $10 generic / $20 preferred brand / $50 Coinsurance non-preferred brand / 50% Coinsurance specialty	
Mail Order Prescription drugs	MedImpact Mail-Order call CVS Caremark 1-800-237-2767 Kaiser Permanente Mail-Order call 1-800-548-9809 or order online at kp.org/refill	
Administered medications, including injections (all outpatient settings)	15% Coinsurance after Deductible	35% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10	35% Coinsurance after Deductible
Maternity Care	**You pay**	
Scheduled prenatal care visits and postpartum visits	$0	35% Coinsurance after Deductible
Laboratory	$20 per department visit	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	35% Coinsurance after Deductible
Inpatient Hospital Services	15% Coinsurance after Deductible	35% Coinsurance after Deductible
Hospital Services	**You pay**	
Ambulance Services (per transport)	15% Coinsurance after Deductible	
Emergency services	15% Coinsurance after Deductible	
Inpatient Hospital Services	15% Coinsurance after Deductible	35% Coinsurance after Deductible
Outpatient Services (other)	**You pay**	
Outpatient surgery visit	15% Coinsurance after Deductible	35% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$30	35% Coinsurance after Deductible
Durable medical equipment	15% Coinsurance after Deductible	35% Coinsurance after Deductible
Physical, speech, and occupational therapies (25 visits per Year)	$30	35% Coinsurance after Deductible
Skilled Nursing Facility Services	**You pay**	
Inpatient skilled nursing Services (up to 60 days per Year)	15% Coinsurance after Deductible	35% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	**You pay**	
Outpatient Services	$20 per visit	35% Coinsurance after Deductible
Inpatient hospital & residential Services	15% Coinsurance after Deductible	35% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**	
Acupuncture Services (up to 12 visits per Year)	$30 per visit	35% Coinsurance after Deductible
Chiropractic Services (up to 10 visits per Year)	$30 per visit	35% Coinsurance after Deductible
Massage Therapy	Not covered	Not covered
Naturopathic Medicine	$20	35% 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	35% 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.)	Not covered	Not covered
Vision hardware and optical Services (For members 19 years and older.)	Not covered	

[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 (covered until the end of the month in which Member turns 19 years of age)	**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: 1-866-616-0047
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.