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 Silver 3000/45 KP Plus w/VX

2024 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)	$3,000	Not applicable
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$3,000	Not applicable
Family Deductible per Year (for an entire Family)	$6,000	Not applicable
Out-of-Pocket Maximum [1]		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$8,700	Not applicable
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$8,700	Not applicable
Family Out-of-Pocket Maximum per Year (for an entire Family)	$17,400	Not applicable

	In-Network	Out-of-Network [2] (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	$45	$65
Specialty Care	$55	$75
Urgent Care	$65	Not covered, except for Services received outside the Service Area [3]
Tests (outpatient)	**You pay**	
Preventive Tests	$0	$0
Laboratory	$35 per department visit	$55 per department visit
X-ray, imaging, and special diagnostic procedures	$45 per department visit	$65 per department visit
CT, MRI, PET scans	40% Coinsurance after Deductible	Not covered

Medications (outpatient)		**You pay**
Prescription drugs (up to a 30-day supply)	$30 generic / $60 preferred brand / 50% coinsurance non-preferred brand / 50% coinsurance after Deductible specialty	$50 generic / $80 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)	$60 generic / $120 preferred brand / 50% Coinsurance non-preferred brand	Not covered
Administered medications, including injections (all outpatient settings)	40% 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	$35 per department visit	$55 per department visit
X-ray, imaging, and special diagnostic procedures	$45 per department visit	$65 per department visit
Inpatient Hospital Services	40% Coinsurance after Deductible	Not covered
Hospital Services		**You pay**
Ambulance Services (per transport)	40% Coinsurance after Deductible	Covered In-Network [3]
Emergency services	40% Coinsurance after Deductible	Covered In-Network [3]
Inpatient Hospital Services	40% Coinsurance after Deductible	Not covered
Outpatient Services (other)		**You pay**
Outpatient surgery visit	40% Coinsurance after Deductible	Not covered
Chemotherapy/radiation therapy visit	$55	Not covered
Durable medical equipment	40% Coinsurance after Deductible	Not covered
Physical, speech, and occupational therapies (25 visits per Year)	$55	$75
Skilled Nursing Facility Services		**You pay**
Inpatient skilled nursing Services (up to 60 days per Year)	40% Coinsurance after Deductible	Not covered
Mental Health and Substance Use Disorder Services		**You pay**
Outpatient Services	$45 per visit	$65 per visit
Inpatient hospital & residential Services	40% Coinsurance after Deductible	Not covered
Alternative Care (self-referred)		**You pay**
Acupuncture Services (up to 12 visits per Year)	$55 per visit	$75 per visit
Chiropractic Services (up to 10 visits per Year)	$55 per visit	$75 per visit
Massage Therapy	Not covered	Not covered
Naturopathic Medicine	$45	$65

Vision Services	You pay	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0	$65
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.)	$45	$65
Vision hardware and optical Services (For members 19 years and older.)	Balance after $200 allowance in a two-Year period.	Not covered

Pediatric Dental (covered until the end of the month in which the Member turns 19 years of age)	**In-network benefit (reimbursement is based on MAC)** [2]	**Out-of-network benefit (reimbursement is based on UCC)** [2]
Preventive and Diagnostic Services (not subject to the Deductible)	**You pay**	
Oral exam, including evaluations and diagnostic exams	$0	$0
Fluoride treatment	$0	$0
Teeth cleaning	$0	$0
Sealants	$0	$0
Space maintainers	$0	$0
X-rays	$0	$0
Minor Restoration Services	**You pay**	
Routine fillings	50% Coinsurance	50% Coinsurance
Simple extractions	50% Coinsurance	50% Coinsurance
Restorations (composite / acrylic and steel)	50% Coinsurance	50% Coinsurance
Oral Surgery Services	**You pay**	
Major oral surgery	50% Coinsurance	50% Coinsurance
Surgical tooth extractions	50% Coinsurance	50% Coinsurance
Periodontics	**You pay**	
Scaling and root planing	50% Coinsurance	50% Coinsurance
Treatment of gum disease	50% Coinsurance	50% Coinsurance
Endodontics	**You pay**	
Root canal and related therapy	50% Coinsurance	50% Coinsurance
Major Restoration Services	**You pay**	
Bridges abutments	50% Coinsurance	50% Coinsurance
Noble metal gold or porcelain crowns	50% Coinsurance	50% Coinsurance
Inlays & Pontics	50% Coinsurance	50% Coinsurance
Removable Prosthetic Services	**You pay**	
Full upper and lower dentures	50% Coinsurance	50% Coinsurance
Partial dentures	50% Coinsurance	50% Coinsurance
Rebases	50% Coinsurance	50% Coinsurance
Relines	50% Coinsurance	50% Coinsurance
Emergency Dental Care or Urgent Dental Care	The Cost Share that normally applies for non-emergency dental care Services	

Other Dental Services (not subject to the Deductible)	**You pay**	
Nightguards	10% Coinsurance	10% Coinsurance
Nitrous oxide		
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

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

[2] 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.**

[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**.

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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

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.