

Summary of Medical Benefits

KP WA Gold 1000/20 w/ VX

2021 Contract

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

Deductible

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

Out-of-Pocket Maximum *

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$7,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$7,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$15,000

Office visits

You pay

Routine preventive physical exam	\$0
Telehealth (phone/video)	\$0
Primary Care	\$20
Specialty Care	\$40
Naturopathic Medicine (up to 6 visits per Year)	\$40 per visit
Urgent Care	\$50

Tests (outpatient)

You pay

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

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
Mail Order Prescription drugs (up to a 90-day supply)	\$20 generic / \$60 preferred brand / 50% Coinsurance non-preferred brand
Administered medications, including injections (all outpatient settings)	25% Coinsurance after Deductible
Nurse treatment room visits to receive injections	\$10

Maternity Care

You pay

Scheduled prenatal care visits and postpartum visits	\$0
Laboratory	\$20 per department visit
X-ray, imaging, and special diagnostic procedures	\$20 per department visit
Inpatient Hospital Services	25% 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
Outpatient Services (other)	You pay
Outpatient surgery visit	25% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	\$40
Durable medical equipment	25% Coinsurance after Deductible
Physical, speech, and occupational therapies (25 visits per therapy/combined per Year)	\$40
Skilled Nursing Facility Services	You pay
Inpatient skilled nursing Services (up to 60 days per Year)	25% Coinsurance after Deductible
Chemical Dependency Services	You pay
Outpatient Services	\$20 per visit
Inpatient hospital & residential Services	25% Coinsurance after Deductible
Mental Health Services	You pay
Outpatient Services	\$20 per visit
Inpatient hospital & residential Services	25% Coinsurance after Deductible
Alternative Care (self-referred)	You pay
Benefit Maximum per Year (not applicable)	Not Applicable
Acupuncture Services (up to 12 visits per Year)	\$40 per visit
Chiropractic Services (up to 10 visits per Year)	\$40 per visit
Massage Therapy	Not Covered
Vision Services	You pay
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	\$0
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.
Routine eye exam (For members 19 years and older.)	\$20
Vision hardware and optical Services (For members 19 years and older.)	Initial allowance of up to \$200 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once in a two-Year period.

Pediatric Dental

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

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

** 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 <http://www.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...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.