

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 w/ VX

2021 Contract

Tier 1
PPO Providers

Tier 2
Non-Participating Providers *

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

Deductible The amounts you pay for covered Services subject to the Deductible in Tier 1 and Tier 2 do not cross accumulate. This means that the amounts you pay for covered Services in Tier 1 only count toward the Tier 1 Deductible and the amounts you pay for covered Services Tier 2 only count toward the Deductible in Tier 2.

	Tier 1 PPO Providers	Tier 2 Non-Participating Providers *
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 **

	Tier 1 PPO Providers	Tier 2 Non-Participating Providers *
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$2,500	\$7,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$2,500	\$7,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$5,000	\$14,000

Office visits

You pay

	Tier 1 PPO Providers	Tier 2 Non-Participating Providers *
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
Naturopathic Medicine	\$30 per visit	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	10% 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)	10% 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	10% Coinsurance after Deductible	35% Coinsurance after Deductible	
Hospital Services		You pay	
Ambulance Services (per transport)	10% Coinsurance after Deductible		
Emergency services	10% Coinsurance after Deductible		
Inpatient Hospital Services	10% Coinsurance after Deductible	35% Coinsurance after Deductible	
Outpatient Services (other)		You pay	
Outpatient surgery visit	10% Coinsurance after Deductible	35% Coinsurance after Deductible	
Chemotherapy/radiation therapy visit	\$30	35% Coinsurance after Deductible	
Durable medical equipment	10% Coinsurance after Deductible	35% Coinsurance after Deductible	
Physical, speech, and occupational therapies (25 visits per therapy/combined per Year)	\$30	35% Coinsurance after Deductible	
Skilled Nursing Facility Services		You pay	
Inpatient skilled nursing Services (up to 60 days per Year)	10% Coinsurance after Deductible	35% Coinsurance after Deductible	
Chemical Dependency Services		You pay	
Outpatient Services	\$20 per visit	35% Coinsurance after Deductible	

Tests (outpatient)		You pay	
Inpatient hospital & residential Services	10% Coinsurance after Deductible	35% Coinsurance after Deductible	
Mental Health Services		You pay	
Outpatient Services	\$20 per visit	35% Coinsurance after Deductible	
Inpatient hospital & residential Services	10% Coinsurance after Deductible	35% 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)	\$30 per visit	35% Coinsurance after Deductible	
Chiropractic Services (up to 10 visits per Year)	\$30	35% Coinsurance after Deductible	
Massage Therapy	Not Covered	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	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 eyeglass lenses, frames or contact lenses every 12 months.	50% Coinsurance after Deductible	
Routine eye exam (For members 19 years and older.)	\$20	35% Coinsurance after Deductible	
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.		

* Tier 2 may be subject to balance billing.

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

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

** 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: 1-866-616-0047

All other areas: 1-866-616-0047 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.