

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

Member Services: 1-800-813-2000

KP WA Silver 2800/25% H.S.A.

2021 Contract

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

Deductible

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|---|---------|
| Self-only Deductible per Year (for a Family of one Member) | \$2,800 |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | \$2,800 |
| Family Deductible per Year (for an entire Family) | \$5,600 |

Out-of-Pocket Maximum *

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|--|----------|
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | \$5,400 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | \$5,400 |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | \$10,800 |

Office visits

You pay

| | |
|---|----------------------------------|
| Routine preventive physical exam | \$0 |
| Telehealth (phone/video) | \$0 after Deductible |
| Primary Care | 25% Coinsurance after Deductible |
| Specialty Care | 25% Coinsurance after Deductible |
| Naturopathic Medicine (up to 6 visits per Year) | 25% Coinsurance after Deductible |
| Urgent Care | 25% Coinsurance after Deductible |

Tests (outpatient)

You pay

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|---|----------------------------------|
| Preventive Tests | \$0 |
| Laboratory | 25% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | 25% Coinsurance after Deductible |
| CT, MRI, PET scans | 25% Coinsurance after Deductible |

Medications (outpatient)

You pay

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|--|---|
| Prescription drugs (up to a 30-day supply) | After Deductible: \$20 generic / \$40 preferred brand / 30% Coinsurance non-preferred brand / 50% Coinsurance specialty |
| Mail Order Prescription drugs (up to a 90-day supply) | After Deductible: \$40 generic / \$80 preferred brand / 30% Coinsurance non-preferred brand |
| Administered medications, including injections (all outpatient settings) | 25% Coinsurance after Deductible |
| Nurse treatment room visits to receive injections | 25% Coinsurance after Deductible |

Maternity Care

You pay

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|--|----------------------------------|
| Scheduled prenatal care visits and postpartum visits | \$0 |
| Laboratory | 25% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | 25% Coinsurance after Deductible |
| 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 | 25% Coinsurance after Deductible |
| Durable medical equipment | 25% Coinsurance after Deductible |
| Physical, speech, and occupational therapies (25 visits per therapy/combined per Year) | 25% Coinsurance after Deductible |
| 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 | 25% Coinsurance after Deductible |
| Inpatient hospital & residential Services | 25% Coinsurance after Deductible |
| Mental Health Services | You pay |
| Outpatient Services | 25% Coinsurance after Deductible |
| 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) | 25% Coinsurance after Deductible |
| Chiropractic Services (up to 10 visits per Year) | 25% Coinsurance after Deductible |
| 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.) | Not Covered |
| Vision hardware and optical Services (For members 19 years and older.) | Not Covered |

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

| 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 |
| Minor Restoration Services | | |
| | You pay | |
| Routine fillings | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Plastic and steel crowns | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Simple extractions | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Oral Surgery Services | | |
| | You pay | |
| Surgical tooth extractions | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Periodontics | | |
| | You pay | |
| Treatment of gum disease | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Scaling and root planing | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Endodontics | | |
| | You pay | |
| Root canal and related therapy | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Major Restoration Services | | |
| | You pay | |
| Gold or porcelain crowns | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Bridges | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Removable Prosthetic Services | | |
| | You pay | |
| Full and partial dentures | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Relines | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Rebases | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| Nitrous oxide | | |
| | You pay | |
| Adults and children age 13 years and older | \$25 after Deductible | \$25 after Deductible |
| Children age 12 years and younger | \$0 | \$0 |
| Orthodontics (medically necessary, diagnosis of cleft palate/lip) | 50% Coinsurance after Deductible | 50% Coinsurance after Deductible |

**"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.