

# 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 5500/50 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)	\$5,500
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$5,500
Family Deductible per Year (for an entire Family)	\$11,000

## Out-of-Pocket Maximum \*

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$8,550
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$8,550
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$17,100

## Office visits

### You pay

Routine preventive physical exam	\$0
Telehealth (phone/video)	\$0
Primary Care	\$50
Specialty Care	\$70
Naturopathic Medicine (up to 6 visits per Year)	\$70 per visit
Urgent Care	35% Coinsurance after Deductible

## Tests (outpatient)

### You pay

Preventive Tests	\$0
Laboratory	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	35% Coinsurance after Deductible
CT, MRI, PET scans	35% Coinsurance after Deductible

## Medications (outpatient)

### You pay

Prescription drugs (up to a 30-day supply)	\$30 generic / \$50 preferred brand / 50% after Deductible non-preferred brand / 50% after Deductible specialty
Mail Order Prescription drugs (up to a 90-day supply)	\$60 generic / \$100 preferred brand / 50% after Deductible non preferred brand
Administered medications, including injections (all outpatient settings)	35% Coinsurance after Deductible
Nurse treatment room visits to receive injections	\$10

## Maternity Care

### You pay

Scheduled prenatal care visits and postpartum visits	\$0
Laboratory	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	35% Coinsurance after Deductible
Inpatient Hospital Services	35% Coinsurance after Deductible

<b>Hospital Services</b>	<b>You pay</b>
Ambulance Services (per transport)	35% Coinsurance after Deductible
Emergency services	35% Coinsurance after Deductible
Inpatient Hospital Services	35% Coinsurance after Deductible
<b>Outpatient Services (other)</b>	<b>You pay</b>
Outpatient surgery visit	35% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	\$70
Durable medical equipment	35% Coinsurance after Deductible
Physical, speech, and occupational therapies (25 visits per therapy/combined per Year)	\$70
<b>Skilled Nursing Facility Services</b>	<b>You pay</b>
Inpatient skilled nursing Services (up to 60 days per Year)	35% Coinsurance after Deductible
<b>Chemical Dependency Services</b>	<b>You pay</b>
Outpatient Services	\$50 per visit
Inpatient hospital & residential Services	35% Coinsurance after Deductible
<b>Mental Health Services</b>	<b>You pay</b>
Outpatient Services	\$50 per visit
Inpatient hospital & residential Services	35% Coinsurance after Deductible
<b>Alternative Care (self-referred)</b>	<b>You pay</b>
Benefit Maximum per Year (not applicable)	Not Applicable
Acupuncture Services (up to 12 visits per Year)	\$70 per visit
Chiropractic Services (up to 10 visits per Year)	\$70 per visit
Massage Therapy	Not Covered
<b>Vision Services</b>	<b>You pay</b>
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.)	\$50
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) \*\***

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