

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

Washington KP PLUS PLAN B 500/20/20%/3000

1/1/2023 - 12/31/2023

	In-Network	Out-of-Network
Calendar year is the time period (Year) in which dollar, day,	and visit limits, Deductible	es and Out-of-Pocket Maximums
accumulate.		
Deductible Services that are subject to the Deductible are i Cost Share amount shown in this summary.	ndicated below. After you	meet your Deductible, you pay the
Self-only Deductible per Year (for a Family of one Member)	\$500	Not applicable
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$500	Not applicable
Family Deductible per Year (for an entire Family)	\$1,500	Not applicable
Out-of-Pocket Maximum ²		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$3,000	Not applicable
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$3,000	Not applicable
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$9,000	Not applicable
		Out-of-Network ¹
	In-Network	(Limited to 10 covered Services per Year, combined)

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	\$20	\$40
Specialty Care	\$30	\$50
Urgent Care	\$40	Not covered, except for Services received outside the Service Area ³

When you receive covered Services from Non-Participating Providers, you pay the Out-of-Network Cost Share shown

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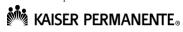
KAISER PERMANENTE®

below.

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You pay		
\$0	\$0	
\$20 per department visit	\$40 per department visit	
\$20 per department visit	\$40 per department visit	
\$100 per department visit	Not covered	
You pay		
Covered based on Rider purchased	Covered based on Rider purchased (Limited to 5 prescription fills per Year) ³	
Covered based on Rider purchased	Not covered	
20% Coinsurance after Deductible	Not covered	
\$10	\$30	
You	pay	
\$0	\$0	
\$20 per department visit	\$40 per department visit	
\$20 per department visit	\$40 per department visit	
20% Coinsurance after Deductible	Not covered	
You pay		
20% Coinsurance after Deductible	Covered In-Network ³	
20% Coinsurance after Deductible	Covered In-Network ³	
20% Coinsurance after Deductible	Not covered	
You	pay	
20% Coinsurance after Deductible	Not covered	
\$30 after Deductible	Not covered	
20% Coinsurance after Deductible	Not covered	
\$30	\$50	
You	ı рау	
20% Coinsurance after Deductible	Not covered	
You	pay	
\$20 per visit	\$40 per visit	
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You \$30 per visit	\$50 per visit	
	\$0 \$20 per department visit \$20 per department visit \$100 per department visit You Covered based on Rider purchased Covered based on Rider purchased 20% Coinsurance after Deductible \$10 You \$0 \$20 per department visit \$20 per department visit 20% Coinsurance after Deductible You 20% Coinsurance after Deductible \$30 after Deductible 20% Coinsurance after Deductible \$30 after Deductible \$30 Coinsurance after Deductible	





Vision Services	You pay	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	\$20	\$40
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	Not covered	Not covered
Routine eye exam (For members 19 years and older.)	\$20	\$40
Vision hardware and optical Services (For members 19 years and older.)	Not covered	Not covered

¹ 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.

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**.

Questions? Call Customer Service at 1-866-616-0047 (M-F, 8 am-6 pm) or visit kp.org.

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 Customer Service. In the case of a conflict between this summary and the EOC, the EOC will prevail.

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² Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

³The 10 covered Services limit does not apply.