

# 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 Silver 3000/45 3T POS**

**2023 Contract**

|   | Select Providers                 | PPO Providers                    | Non-Participating Providers <sup>1</sup> |
|---|----------------------------------|----------------------------------|--|
| Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.  |                                  |                                  |  |
| <b>Deductible</b>   |                                  |                                  |  |
| For Services that are subject to the Deductible, the amounts you pay for covered Services from Select Providers also count toward the Deductible for Services from PPO Providers, and vice versa. The amounts you pay for Services from Non-Participating Providers only count toward the Deductible for Services from Non-Participating Providers. |                                  |                                  |  |
| Self-only Deductible per Year (for a Family of one Member)  | \$3,000                          | \$5,000                          | \$7,000                                  |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)   | \$3,000                          | \$5,000                          | \$7,000                                  |
| Family Deductible per Year (for an entire Family)   | \$6,000                          | \$10,000                         | \$14,000                                 |
| <b>Out-of-Pocket Maximum <sup>2</sup></b>   |                                  |                                  |  |
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)   | \$8,900                          | \$8,900                          | \$14,000                                 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)  | \$8,900                          | \$8,900                          | \$14,000                                 |
| Family Out-of-Pocket Maximum per Year (for an entire Family)  | \$17,800                         | \$17,800                         | \$28,000                                 |
| <b>Office Visits</b>  |                                  | <b>You pay</b>                   |  |
| Routine preventive physical exam  | \$0                              | \$0                              | 50% Coinsurance after Deductible         |
| Telehealth (phone/video)  | \$0                              | \$0                              | 50% Coinsurance after Deductible         |
| Primary Care  | \$45                             | \$60                             | 50% Coinsurance after Deductible         |
| Specialty Care  | \$55                             | \$70                             | 50% Coinsurance after Deductible         |
| Urgent Care   | \$65                             | \$80                             | 50% Coinsurance after Deductible         |
| <b>Tests (outpatient)</b>   |                                  | <b>You pay</b>                   |  |
| Preventive Tests  | \$0                              | \$0                              | 50% Coinsurance after Deductible         |
| Laboratory  | \$45 per department visit        | 45% Coinsurance after Deductible | 50% Coinsurance after Deductible         |
| X-ray, imaging, and special diagnostic procedures   | \$45 per department visit        | 45% Coinsurance after Deductible | 50% Coinsurance after Deductible         |
| CT, MRI, PET scans  | 40% Coinsurance after Deductible | 45% Coinsurance after Deductible | 50% Coinsurance after Deductible         |

| Medications (outpatient)   |  | You pay   |                                  |
|--|--|---|----------------------------------|
| Prescription drugs (up to a 30-day supply)                               | \$30 generic / \$60 preferred brand / 50% coinsurance non-preferred brand / 50% coinsurance after Deductible specialty | At MedImpact Pharmacy<br>\$40 generic / \$70 preferred brand / 50% coinsurance non-preferred brand / 50% coinsurance after Deductible specialty |                                  |
| Mail Order Prescription drugs (up to a 90day supply)                     | \$60 generic / \$120 preferred brand / 50% Coinsurance non-preferred brand   | MedImpact Mail-Order call CVS Caremark 1-800-237-2767   |                                  |
| Administered medications, including injections (all outpatient settings) | 40% Coinsurance after Deductible   | 45% Coinsurance after Deductible  | 50% Coinsurance after Deductible |
| Nurse treatment room visits to receive injections                        | \$10   | \$60  | 50% Coinsurance after Deductible |
| Maternity Care   |  | You pay   |                                  |
| Scheduled prenatal care visits and postpartum visit                      | \$0  | \$0   | 50% Coinsurance after Deductible |
| Laboratory   | \$45 per department visit  | 45% Coinsurance after Deductible  | 50% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures                        | \$45 per department visit  | 45% Coinsurance after Deductible  | 50% Coinsurance after Deductible |
| Inpatient Hospital Services  | 40% Coinsurance after Deductible   | 45% Coinsurance after Deductible  | 50% Coinsurance after Deductible |
| Hospital Services  |  | You pay   |                                  |
| Ambulance Services (per transport)                                       | 40% Coinsurance after Deductible   |   |                                  |
| Emergency services   | 40% Coinsurance after Deductible   |   |                                  |
| Inpatient Hospital Services  | 40% Coinsurance after Deductible   | 45% Coinsurance after Deductible  | 50% Coinsurance after Deductible |
| Outpatient Services (other)  |  | You pay   |                                  |
| Outpatient surgery visit   | 40% Coinsurance after Deductible   | 45% Coinsurance after Deductible  | 50% Coinsurance after Deductible |
| Chemotherapy/radiation therapy visit                                     | \$55   | \$70  | 50% Coinsurance after Deductible |
| Durable medical equipment  | 40% Coinsurance after Deductible   | 45% Coinsurance after Deductible  | 50% Coinsurance after Deductible |
| Physical, speech, and occupational therapies (25 visits per Year)        | \$55   | \$70  | 50% Coinsurance after Deductible |
| Skilled Nursing Facility Services  |  | You pay   |                                  |
| Inpatient skilled nursing Services (up to 60 days per Year)              | 40% Coinsurance after Deductible   | 45% Coinsurance after Deductible  | 50% Coinsurance after Deductible |
| Mental Health and Substance Use Disorder Services                        |  | You pay   |                                  |
| Outpatient Services  | \$45 per visit   | \$60 per visit  | 50% Coinsurance after Deductible |
| Inpatient hospital & residential Services                                | 40% Coinsurance after Deductible   | 45% Coinsurance after Deductible  | 50% Coinsurance after Deductible |

| <b>Alternative Care</b> (self-referred)  |   | <b>You pay</b> |                                  |
|--|---|----------------|----------------------------------|
| Acupuncture Services (up to 12 visits per Year)  | \$55 per visit  | \$70 per visit | 50% Coinsurance after Deductible |
| Chiropractic Services (up to 10 visits per Year)   | \$55 per visit  | \$70 per visit | 50% Coinsurance after Deductible |
| Massage Therapy  | Not covered   | Not covered    | Not covered                      |
| Naturopathic Medicine  | \$45  | \$60           | 50% Coinsurance after Deductible |
| <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   | \$0            | 50% 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 one pair standard frames and lenses or 12-month supply contact lenses per year. |                | 50% Coinsurance after Deductible |
| Routine eye exam (For members 19 years and older.)   | Not covered   | Not covered    | Not covered                      |
| Vision hardware and optical Services (For members 19 years and older.)   | Not covered   |                |                                  |

<sup>1</sup> Non-Participating Providers may be subject to balance billing.

<sup>2</sup> 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) <sup>3</sup>

**Out-of-network benefit**  
(reimbursement is based  
on UCC) <sup>3</sup>

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

<sup>3</sup> "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 [kp.org/plandocuments](https://kp.org/plandocuments).

**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit [kp.org](https://kp.org) Portland area: 503-813-2000

All other areas: 1-800-813-2000. 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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.