

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

KP WA Platinum 250/20 PPO Plus

2024 Contract

PPO Providers

Non-Participating Providers ¹

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

Deductible For Services that are subject to the Deductible, the amounts you pay for covered Services from PPO Providers do not count toward the Deductible for Services from Non-Participating Providers, and vice versa.

| | | |
|---|-------|---------|
| 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 ²

| | | |
|--|---------|----------|
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | \$3,000 | \$7,000 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | \$3,000 | \$7,000 |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | \$6,000 | \$14,000 |

Office Visits

You pay

| | | |
|----------------------------------|------|----------------------------------|
| 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 |
| 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 | 15% 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) | 15% 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 | 15% Coinsurance after Deductible | 35% Coinsurance after Deductible |
| Hospital Services | | You pay |
| Ambulance Services (per transport) | 15% Coinsurance after Deductible | |
| Emergency services | 15% Coinsurance after Deductible | |
| Inpatient Hospital Services | 15% Coinsurance after Deductible | 35% Coinsurance after Deductible |
| Outpatient Services (other) | | You pay |
| Outpatient surgery visit | 15% Coinsurance after Deductible | 35% Coinsurance after Deductible |
| Chemotherapy/radiation therapy visit | \$30 | 35% Coinsurance after Deductible |
| Durable medical equipment | 15% Coinsurance after Deductible | 35% Coinsurance after Deductible |
| Physical, speech, and occupational therapies (25 visits per Year) | \$30 | 35% Coinsurance after Deductible |
| Skilled Nursing Facility Services | | You pay |
| Inpatient skilled nursing Services (up to 60 days per Year) | 15% Coinsurance after Deductible | 35% Coinsurance after Deductible |
| Mental Health and Substance Use Disorder Services | | You pay |
| Outpatient Services | \$20 per visit | 35% Coinsurance after Deductible |
| Inpatient Hospital & residential Services | 15% Coinsurance after Deductible | 35% Coinsurance after Deductible |

| Alternative Care (self-referred) | | You pay |
|--|---|----------------------------------|
| Acupuncture Services (up to 12 visits per Year) | \$30 per visit | 35% Coinsurance after Deductible |
| Chiropractic Services (up to 10 visits per Year) | \$30 per visit | 35% Coinsurance after Deductible |
| Massage Therapy | Not covered | Not covered |
| Naturopathic Medicine | \$20 | 35% 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.) | \$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 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 |
| Vision hardware and optical Services (For members 19 years and older.) | Not covered | |

Pediatric Dental

(covered until the end of the month in which Member turns 19 years of age)

In-network benefit
(reimbursement is based on MAC) ³

Out-of-network benefit
(reimbursement is based on UCC) ³

| Preventive and Diagnostic Services (not subject to the Deductible) | | You pay |
|---|-----------------|-----------------|
| Oral exam, including evaluations and diagnostic exams | \$0 | \$0 |
| Fluoride treatment | \$0 | \$0 |
| Teeth cleaning | \$0 | \$0 |
| Sealants | \$0 | \$0 |
| Space maintainers | \$0 | \$0 |
| X-rays | \$0 | \$0 |
| Minor Restoration Services | | You pay |
| Routine fillings | 50% Coinsurance | 50% Coinsurance |
| Simple extractions | 50% Coinsurance | 50% Coinsurance |
| Restorations (composite / acrylic and steel) | 50% Coinsurance | 50% Coinsurance |
| Oral Surgery Services | | You pay |
| Major oral surgery | 50% Coinsurance | 50% Coinsurance |
| Surgical tooth extractions | 50% Coinsurance | 50% Coinsurance |
| Periodontics | | You pay |
| Scaling and root planing | 50% Coinsurance | 50% Coinsurance |
| Treatment of gum disease | 50% Coinsurance | 50% Coinsurance |
| Endodontics | | You pay |
| Root canal and related therapy | 50% Coinsurance | 50% Coinsurance |
| Major Restoration Services | | You pay |
| Bridges abutments | 50% Coinsurance | 50% Coinsurance |
| Noble metal gold or porcelain crowns | 50% Coinsurance | 50% Coinsurance |
| Inlays & Pontics | 50% Coinsurance | 50% Coinsurance |

Pediatric Dental

(covered until the end of the month in which Member turns 19 years of age)

In-network benefit
(reimbursement is based on MAC)³

Out-of-network benefit
(reimbursement is based on UCC)³

Removable Prosthetic Services**You pay**

| | | |
|-------------------------------|-----------------|-----------------|
| Full upper and lower dentures | 50% Coinsurance | 50% Coinsurance |
| Partial dentures | 50% Coinsurance | 50% Coinsurance |
| Rebases | 50% Coinsurance | 50% Coinsurance |
| Relines | 50% Coinsurance | 50% Coinsurance |

Emergency Dental Care or Urgent Dental Care

The Cost Share that normally applies for non-emergency dental care Services

Other Dental Services (not subject to the Deductible)**You pay**

| | | |
|--|-----------------|-----------------|
| Nightguards | 10% Coinsurance | 10% Coinsurance |
| Nitrous oxide | | |
| 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

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 PPO hospital or ambulatory surgical center. For additional information, visit <https://healthy.kaiserpermanente.org/oregon-washington/support/pay-bills/medical-bills/no-surprises-act>.

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

³ "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.

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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.