

# 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 500/20 w/VX**

**2024 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)  | \$500   |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | \$500   |
| Family Deductible per Year (for an entire Family)   | \$1,000 |

## Out-of-Pocket Maximum <sup>1</sup>

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

## Office Visits

|                                  | You pay |
|----------------------------------|---------|
| Routine preventive physical exam | \$0     |
| Telehealth (phone/video)         | \$0     |
| Primary Care                     | \$20    |
| Specialty Care                   | \$30    |
| Urgent Care                      | \$40    |

## Tests (outpatient)

|   | You pay                          |
|---|----------------------------------|
| Preventive Tests                                  | \$0                              |
| Laboratory  | \$20 per department visit        |
| X-ray, imaging, and special diagnostic procedures | \$20 per department visit        |
| CT, MRI, PET scans                                | 20% Coinsurance after Deductible |

## Medications (outpatient)

|  | You pay   |
|--|---|
| Prescription drugs (up to a 30-day supply)                               | \$5 generic / \$15 preferred brand / \$50 non-preferred brand / 50% Coinsurance specialty |
| Mail Order Prescription drugs (up to a 90-day supply)                    | \$10 generic / \$30 preferred brand / \$100 non-preferred brand                           |
| Administered medications, including injections (all outpatient settings) | 20% Coinsurance after Deductible  |
| Nurse treatment room visits to receive injections                        | \$10  |

## Maternity Care

|  | You pay                          |
|--|----------------------------------|
| Scheduled prenatal care visits and postpartum visits | \$0                              |
| Laboratory   | \$20 per department visit        |
| X-ray, imaging, and special diagnostic procedures    | \$20 per department visit        |
| Inpatient Hospital Services                          | 20% Coinsurance after Deductible |

|  |  |
|--|--|
| <b>Hospital Services</b>   | <b>You pay</b>   |
| Ambulance Services (per transport)   | 20% Coinsurance after Deductible   |
| Emergency services   | 20% Coinsurance after Deductible   |
| Inpatient Hospital Services  | 20% Coinsurance after Deductible   |
| <b>Outpatient Services (other)</b>   | <b>You pay</b>   |
| Outpatient surgery visit   | 20% Coinsurance after Deductible   |
| Chemotherapy/radiation therapy visit   | \$30   |
| Durable medical equipment  | 20% Coinsurance after Deductible   |
| Physical, speech, and occupational therapies (25 visits per Year)  | \$30   |
| <b>Skilled Nursing Facility Services</b>   | <b>You pay</b>   |
| Inpatient skilled nursing Services (up to 60 days per Year)  | 20% Coinsurance after Deductible   |
| <b>Mental Health and Substance Use Disorder Services</b>   | <b>You pay</b>   |
| Outpatient Services  | \$20 per visit   |
| Inpatient hospital & residential Services  | 20% Coinsurance after Deductible   |
| <b>Alternative Care (self-referred)</b>  | <b>You pay</b>   |
| Acupuncture Services (up to 12 visits per Year)  | \$30 per visit   |
| Chiropractic Services (up to 10 visits per Year)   | \$30 per visit   |
| Massage Therapy  | Not covered  |
| Naturopathic Medicine  | \$20   |
| <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.)   | \$20   |
| Vision hardware and optical Services (For members 19 years and older.)   | Balance after \$200 allowance in a two-Year period.                      |

|   |  |  |
|---|--|--|
| <b>Pediatric Dental</b><br>(covered until the end of the month in which the Member turns 19 years of age) | <b>In-network benefit<br/>(reimbursement is based<br/>on MAC) <sup>2</sup></b> | <b>Out-of-network benefit<br/>(reimbursement is based<br/>on UCC) <sup>2</sup></b> |
| <b>Preventive and Diagnostic Services</b> (not subject to the Deductible)                                 | <b>You pay</b>   |  |
| 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  |
| <b>Minor Restoration Services</b>   | <b>You pay</b>   |  |
| Routine fillings  | 50% Coinsurance  | 50% Coinsurance  |
| Simple extractions  | 50% Coinsurance  | 50% Coinsurance  |
| Restorations (composite / acrylic and steel)  | 50% Coinsurance  | 50% Coinsurance  |
| <b>Oral Surgery Services</b>  | <b>You pay</b>   |  |
| Major oral surgery  | 50% Coinsurance  | 50% Coinsurance  |
| Surgical tooth extractions  | 50% Coinsurance  | 50% Coinsurance  |

| <b>Periodontics</b>  |   | <b>You pay</b>  |
|--|---|-----------------|
| Scaling and root planing   | 50% Coinsurance   | 50% Coinsurance |
| Treatment of gum disease   | 50% Coinsurance   | 50% Coinsurance |
| <b>Endodontics</b>   |   | <b>You pay</b>  |
| Root canal and related therapy   | 50% Coinsurance   | 50% Coinsurance |
| <b>Major Restoration Services</b>  |   | <b>You pay</b>  |
| Bridges abutments  | 50% Coinsurance   | 50% Coinsurance |
| Noble metal gold or porcelain crowns                                     | 50% Coinsurance   | 50% Coinsurance |
| Inlays & Pontics   | 50% Coinsurance   | 50% Coinsurance |
| <b>Removable Prosthetic Services</b>                                     |   | <b>You pay</b>  |
| 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 |
| <b>Emergency Dental Care or Urgent Dental Care</b>                       | The Cost Share that normally applies for non-emergency dental care Services |                 |
| <b>Other Dental Services</b> (not subject to the Deductible)             |   | <b>You pay</b>  |
| 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             |
| <b>Orthodontics</b> (medically necessary, diagnosis of cleft palate/lip) | 50% Coinsurance   | 50% Coinsurance |

<sup>1</sup> Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

<sup>2</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**.

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>**.

**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, 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.