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 Platinum 250/10 3T POS W/VX

2018 Contract

	Tier 1 Select Providers	Tier 2 PPO Providers	Tier 3 Non-Participating Providers *
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.			
Deductible The amounts you pay for covered Services subject to the Deductible in Tier 1 and Tier 2 cross accumulate. This means that the amounts you pay for covered Services in Tier 1 also count toward the Deductible in Tier 2, and do not count toward the Deductible in Tier 3. The amounts you pay for covered Services subject to the Deductible in Tier 3 only count toward the Deductible in Tier 3.			
For one Member per Year	$250	$500	$750
For an entire Family per Year	$500	$1,000	$1,500
Out-of-Pocket Maximum **			
For one Member per year	$2,000	$3,000	$6,000
For an entire Family per year	$4,000	$6,000	$12,000
Office visits		**You pay**	
Routine preventive physical exam	$0	$0	35% Coinsurance after Deductible
Primary Care	$10	$25	35% Coinsurance after Deductible
Specialty Care	$20	$35	35% Coinsurance after Deductible
Urgent Care	$40	$55	35% Coinsurance after Deductible
Tests (outpatient)		**You pay**	
Preventive Tests	$0	$0	35% Coinsurance after Deductible
Laboratory	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$10 per department visit	$25 per department visit	35% Coinsurance after Deductible
CT, MRI, PET scans	$100 per department visit	25% Coinsurance after Deductible	35% Coinsurance after Deductible

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Medications (outpatient)		**You pay**	
Prescription drugs (up to a 30 day supply)	$10 generic / $20 preferred brand / $50 non-preferred brand / 50% Coinsurance specialty	At MedImpact Pharmacy $15 generic/$30 preferred brand/50% Coinsurance non-preferred brand/50% Coinsurance for specialty drugs	
Mail Order Prescription drugs (up to a 90 day supply)	$20 generic / $40 preferred brand / $100 non-preferred brand	Refer to Mail-Delivery Pharmacy 1-800-548-9809 kp.org/addedchoice	
Administered medications, including injections (all outpatient settings)	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10	$20	35% Coinsurance after Deductible
Maternity Care		**You pay**	
Scheduled prenatal care and first postpartum visit	$0	$0	35% Coinsurance after Deductible
Laboratory	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$10 per department visit	$25 per department visit	35% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Hospital Services		**You pay**	
Ambulance Services (per transport)	10% Coinsurance		
Emergency department visit	$100 after Deductible (Waived if admitted)		
Inpatient Hospital Services	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Outpatient Services (other)		**You pay**	
Outpatient surgery visit	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$20	$35	35% Coinsurance after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible	35% Coinsurance after Deductible	45% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 25 visits combined per Year)	$20	$35	35% Coinsurance after Deductible
Skilled Nursing Facility Services		**You pay**	
Inpatient skilled nursing Services (up to 60 days per Year)	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Chemical Dependency Services		**You pay**	
Outpatient Services	$10	$25	35% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible

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Mental Health Services		**You pay**	
Outpatient Services	$10	$25	35% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible	25% Coinsurance after Deductible	35% Coinsurance after Deductible
Alternative Care (self-referred)***		**You pay**	
Benefit Maximum per Year (all self-referred Services and all tiers combined)	Not Applicable		
Acupuncture Services up to 12 visits per Year	$20	$35	35% Coinsurance after Deductible
Chiropractic Services up to 10 visits per Year	$20	$35	35% Coinsurance after Deductible
Massage Therapy	Not Covered	Not Covered	Not Covered
Naturopathic Medicine	Not Covered	$35	35% Coinsurance after Deductible
Vision Services		**You pay**	
Routine eye exam (through first month of age 19)	$0	$0	35% Coinsurance after Deductible
Vision hardware and optical Services (through first month of age 19)	No charge for eyeglass lenses or frames or contact lenses every 12 months.		50% Coinsurance after Deductible
Routine eye exam (age 19 and older)	$10	$25	35% Coinsurance
Vision hardware and optical Services (age 19 years and older)	Initial allowance of up to $200 for eyeglasses or contact lenses, not more than once in a two year period.		

* Tier 3 may be subject to balance billing.

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

***Refer to your Evidence of Coverage (EOC) for any applicable visits limits.

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Pediatric Dental	In-network benefit (reimbursement is based on MAC) *	Out-of-network benefit (reimbursement is based on UCC) *
Benefit Maximum	None	
Deductible	**You pay**	
For one Member	$0	
For an entire Family	$0	
Preventive and Diagnostic Services	**You pay**	
Oral exam	No additional charge	No additional charge
X-rays	No additional charge	No additional charge
Teeth cleaning	No additional charge	No additional charge
Fluoride	No additional charge	No additional charge
Basic Restoration Services	**You pay**	
Routine fillings	50% Coinsurance	50% Coinsurance
Plastic and steel crowns	50% Coinsurance	50% Coinsurance
Simple extractions	50% Coinsurance	50% Coinsurance
Oral Surgery Services	**You pay**	
Surgical tooth extractions	50% Coinsurance	50% Coinsurance
Periodontics	**You pay**	
Treatment of gum disease	50% Coinsurance	50% Coinsurance
Scaling and root planing	50% Coinsurance	50% Coinsurance
Endodontics	**You pay**	
Root canal therapy	50% Coinsurance	50% Coinsurance
Major Restoration Services	**You pay**	
Gold or porcelain crowns	50% Coinsurance	50% Coinsurance
Bridges	50% Coinsurance	50% Coinsurance
Removable Prosthetic Services	**You pay**	
Full and partial dentures	50% Coinsurance	50% Coinsurance
Relines	50% Coinsurance	50% Coinsurance
Rebases	50% Coinsurance	50% Coinsurance
Nitrous oxide (Not subject to or counted toward the Deductible or Benefit Maximum)	**You pay**	
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

*"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 benefit summary 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.

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