KAISER PERMANENTE®

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

Member Services: 1-800-813-2000

KP WA Silver 2800/25% H.S.A. w/ VX

2021 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)	$2,800
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$2,800
Family Deductible per Year (for an entire Family)	$5,600
Out-of-Pocket Maximum *	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$5,400
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$5,400
Family Out-of-Pocket Maximum per Year (for an entire Family)	$10,800
Office visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0 after Deductible
Primary Care	25% Coinsurance after Deductible
Specialty Care	25% Coinsurance after Deductible
Naturopathic Medicine (up to 6 visits per Year)	25% Coinsurance after Deductible
Urgent Care	25% Coinsurance after Deductible
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	25% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	25% Coinsurance after Deductible
CT, MRI, PET scans	25% Coinsurance after Deductible
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30-day supply)	After Deductible: $20 generic / $40 preferred brand / 30% Coinsurance non-preferred brand / 50% Coinsurance specialty
Mail Order Prescription drugs (up to a 90-day supply)	After Deductible: $40 generic / $80 preferred brand / 30% Coinsurance non-preferred brand
Administered medications, including injections (all outpatient settings)	25% Coinsurance after Deductible
Nurse treatment room visits to receive injections	25% Coinsurance after Deductible
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	25% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	25% Coinsurance after Deductible
Inpatient Hospital Services	25% Coinsurance after Deductible

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Hospital Services	**You pay**
Ambulance Services (per transport)	25% Coinsurance after Deductible
Emergency services	25% Coinsurance after Deductible
Inpatient Hospital Services	25% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	25% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	25% Coinsurance after Deductible
Durable medical equipment	25% Coinsurance after Deductible
Physical, speech, and occupational therapies (25 visits per therapy/combined per Year)	25% Coinsurance after Deductible
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 60 days per Year)	25% Coinsurance after Deductible
Chemical Dependency Services	**You pay**
Outpatient Services	25% Coinsurance after Deductible
Inpatient hospital & residential Services	25% Coinsurance after Deductible
Mental Health Services	**You pay**
Outpatient Services	25% Coinsurance after Deductible
Inpatient hospital & residential Services	25% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**
Benefit Maximum per Year (not applicable)	Not Applicable
Acupuncture Services (up to 12 visits per Year)	25% Coinsurance after Deductible
Chiropractic Services (up to 10 visits per Year)	25% Coinsurance after Deductible
Massage Therapy	Not Covered
Vision Services	**You pay**
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.)	25% Coinsurance after Deductible
Vision hardware and optical Services (For members 19 years and older.)	Initial allowance of up to $200 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once in a two-Year period.

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

* ”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 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.

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