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 Gold 1000/20 w/VX

2018 Contract

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

Deductible	
For one Member per Year	$1,000
For an entire Family per Year	$2,000
Out-of-Pocket Maximum *	
For one Member per year	$6,000
For an entire Family per year	$12,000
Office visits	**You pay**
Routine preventive physical exam	$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	$300 per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30 day supply)	$10 generic / $20 preferred brand / $60 non-preferred brand / 50% Coinsurance specialty
Mail Order Prescription drugs (up to a 90 day supply)	$20 generic / $40 preferred brand / $120 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 and first postpartum visit	$0
Laboratory	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$20 per department visit
Inpatient Hospital Services	20% Coinsurance after Deductible
Hospital Services	**You pay**
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency department visit	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible

Outpatient Services (other)	**You pay**
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$30
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 25 visits combined per Year)	$30
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 60 days per Year)	20% Coinsurance after Deductible
Chemical Dependency Services	**You pay**
Outpatient Services	$20
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	**You pay**
Outpatient Services	$20
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care (self referred)	**You pay**
Benefit Maximum per Year	Not Applicable
Acupuncture Services up to 12 visits per Year	$30
Chiropractic Services up to 10 visits per Year	$30
Massage Therapy	Not Covered
Naturopathic Medicine	Not Covered
Vision Services	**You pay**
Routine eye exam (through first month of age 19)	$0
Vision hardware and optical Services (through first month of age 19)	No charge for eyeglass lenses or frames or contact lenses every 12 months.
Routine eye exam (age 19 and older)	$20
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.

*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) *
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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