Health Plan Benefit Summary

KAISER PERMANENTE®

KPNW Plan Summary

Effective Date: 8/1/2019

NOTE: This is a benefit summary, only, and is not intended to replace the specifics of the plan's Certificate of Coverage, Contract, or Evidence of Insurance. If there is a contradiction, the Certificate of Coverage, Contract, or Evidence of Insurance will take precedence.

Out-of-Pocket Maximum (Note: All Co-payment and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.)	
For one Member	$1,250
For an entire Family	$2,500
Office visits	
Routine preventative physical exam	$0
Primary Care	$15
Specialty Care	$15
Urgent Care	$30
Tests (outpatient)	
Preventive Tests	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$50 per department visit
Medications (outpatient)	
Prescription drugs (up to a 30 day supply)	$5 generic/$20 preferred brand/$50 non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	$10 generic/$40 preferred brand/$100 non-preferred brand
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$5
Maternity Care	
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
Inpatient Hospital Services	$100 per admission
Infertility	
Medical and surgical services for the treatment of sterility and infertility and all related services	Covered subject to the applicable outpatient services cost shares, limited to $30,000 per lifetime maximum. Includes artificial insemination, in-vitro fertilization, and assisted reproduction, including gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT). **Fertility drugs:** Covered subject to 50% plan coinsurance, limited to a lifetime maximum of $5,000

Services Continued	
Hospital Services	
Ambulance Services (per transport)	$75
Emergency department visit	$200 (Waived if admitted)
Inpatient Hospital Services	$100 per admission
Chemotherapy/radiation therapy visit	$15
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$15
Skilled Nursing Facility Services	
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	$0
Chemical Dependency Services	
Outpatient Services (Group visit ½ co-pay)	$0
Inpatient hospital & residential Services	$100 per admission
Mental Health Services	
Outpatient Services (Group visit ½ co-pay)	$0
Inpatient hospital & residential Services	$100 per admission
Alternative Care	
Alternative care (self-referred)	$15 per chiropractor visit
Vision Services	
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)	$10
Vision hardware and optical Services (ages 19 years and older)*	Initial allowance of up to $300 for eyeglasses or contact lenses, not more than once in a one Year period.

* Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.

Additional Features

Online Access anytime, anywhere at no additional charge: kp.org
Access medical records
Refill Prescriptions
Email doctor
Check lab results
Schedule appointments
Health Risk Assessments – personal online tool for members
Facilities and Services: kp.org/facilities
37 Medical offices
8 Urgent Care locations
17 Dental offices
The Portland Clinic (7 locations)
24-hour advice nurses
Health coach services
Member Discounts: kp.org/choosehealthy
CHP Active and Healthy
Fitness club discounts
Vitamins & supplements
Alternative and chiropractic care

Exclusions and Limitations: The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the Evidence of Coverage (EOC). For a complete list and description of Exclusions and Limitations please refer to EOC. Acupuncture unless your employer Group has purchased the "Alternative Care Services Rider". Chiropractic unless your employer Group has purchased the "Alternative Care Services Rider" or the "Chiropractic Services Rider" (for self-referred chiropractic care). Cosmetic Services; This exclusion does not apply to Services that are covered under "Reconstructive Surgery Services" in the "Benefits" section of the EOC. Custodial Services. Dental Services. Designated Blood Donations. Employer Responsibility; We do not reimburse the employer for any Services that the law requires an employer to provide. Experimental or Investigational Services. Eye Surgery; Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures. Family Services; Services provided by a member of your immediate family. Genetic Testing. Hearing Aids unless your Group has purchased the "Hearing Aid Rider." Hypnotherapy. Infertility Services unless your group has purchased the "Infertility Treatment Services Rider." Intermediate Services; Services in an intermediate care facility are excluded. Low-Vision Aids. Massage Therapy Services unless your employer Group has purchased the "Alternative Care Services Rider". Naturopathy Services unless your employer Group has purchased the "Alternative Care Services Rider". Non-Medically Necessary Services. Services Related to a Non-Covered Service. Services That are Not Health Care Services, Supplies, or Items. Supportive Care and Other Services. Surrogacy. Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Travel and Lodging. Travel Services. All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless your Group has purchased the "Travel Services Rider." Vision Hardware and Optical Services unless your Group has purchased an "Adult Vision Hardware and Optical Services Rider" and/or "Pediatric Vision Hardware and Optical Services Rider." Vision Therapy and Orthoptics or Eye Exercises. 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 Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.