# 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

Customer Service: 1-866-616-0047

**KP WA Bronze 7000/50 KP Plus w/VX**

**2023 Contract**

| | In-Network | Out-of-Network |
|---|---|---|
| Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate. | | |
| **Deductible** Services that are subject to the Deductible are indicated below. After you meet your Deductible, you pay the Cost Share amount shown in this summary. | | |
| Self-only Deductible per Year (for a Family of one Member) | $7,000 | Not applicable |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | $7,000 | Not applicable |
| Family Deductible per Year (for an entire Family) | $14,000 | Not applicable |
| **Out-of-Pocket Maximum** [2] | | |
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | $9,000 | Not applicable |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | $9,000 | Not applicable |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | $18,000 | Not applicable |

| | In-Network | Out-of-Network [1] (Limited to 10 covered Services per Year, combined) |
|---|---|---|
| When you receive covered Services from Participating Providers, you pay the In-Network Cost Share shown below. When you receive covered Services from Non-Participating Providers, you pay the Out-of-Network Cost Share shown below. | | |
| **Office Visits** | **You pay** | |
| Routine preventive physical exam | $0 | $0 |
| Telehealth (phone/video) | $0 | Cost Share applicable to the Service when provided in person |
| Primary Care | $50 | $70 |
| Specialty Care | $70 after Deductible | $90 |
| Urgent Care | 40% Coinsurance after Deductible | Not covered, except for Services received outside the Service Area [3] |

| **Tests (outpatient)** | **You pay** | |
|---|---|---|
| Preventive Tests | $0 | $0 |
| Laboratory | 40% Coinsurance after Deductible | 50% Coinsurance |
| X-ray, imaging, and special diagnostic procedures | 40% Coinsurance after Deductible | 50% Coinsurance |
| CT, MRI, PET scans | 40% Coinsurance after Deductible | Not covered |
| **Medications (outpatient)** | **You pay** | |
| Prescription drugs (up to a 30-day supply) | $30 generic / $60 preferred brand / 50% Coinsurance after Deductible non-preferred brand / 50% Coinsurance after Deductible specialty | $50 generic / $80 preferred brand / 50% Coinsurance non-preferred brand / 50% Coinsurance for specialty drugs (Limited to 5 prescription fills per Year) [3] |
| Mail Order Prescription drugs (up to a 90-day supply) | $60 generic/ $120 preferred brand/ 50% Coinsurance after Deductible non-preferred brand | Not covered |
| Administered medications, including injections (all outpatient settings) | 40% Coinsurance after Deductible | Not covered |
| Nurse treatment room visits to receive injections | $10 | $30 |
| **Maternity Care** | **You pay** | |
| Scheduled prenatal care visits and postpartum visits | $0 | $0 |
| Laboratory | 40% Coinsurance after Deductible | 50% Coinsurance |
| X-ray, imaging, and special diagnostic procedures | 40% Coinsurance after Deductible | 50% Coinsurance |
| Inpatient Hospital Services | 40% Coinsurance after Deductible | Not covered |
| **Hospital Services** | **You pay** | |
| Ambulance Services (per transport) | 40% Coinsurance after Deductible | Covered In-Network [3] |
| Emergency services | 40% Coinsurance after Deductible | Covered In-Network [3] |
| Inpatient Hospital Services | 40% Coinsurance after Deductible | Not covered |
| **Outpatient Services (other)** | **You pay** | |
| Outpatient surgery visit | 40% Coinsurance after Deductible | Not covered |
| Chemotherapy/radiation therapy visit | $70 after Deductible | Not covered |
| Durable medical equipment | 40% Coinsurance after Deductible | Not covered |
| Physical, speech, and occupational therapies (25 visits per Year) | $70 after Deductible | $90 |
| **Skilled Nursing Facility Services** | **You pay** | |
| Inpatient skilled nursing Services (up to 60 days per Year) | 40% Coinsurance after Deductible | Not covered |

| **Mental Health and Substance Use Disorder Services** | **You pay** | |
|---|---|---|
| Outpatient Services | $50 per visit | $70 per visit |
| Inpatient hospital & residential Services | 40% Coinsurance after Deductible | Not covered |
| **Alternative Care** (self-referred) | **You pay** | |
| Acupuncture Services (up to 12 visits per Year) | $70 per visit after Deductible | $90 per visit |
| Chiropractic Services (up to 10 visits per Year) | $70 per visit after Deductible | $90 per visit |
| Massage Therapy | Not covered | Not covered |
| Naturopathic Medicine | $50 | $70 |
| **Vision Services** | **You pay** | |
| Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.) | $0 | $70 |
| 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. | Not covered |
| Routine eye exam (For members 19 years and older.) | $50 | $70 |
| Vision hardware and optical Services (For members 19 years and older.) | Balance after $200 allowance in a two-Year period. | Not covered |

[1] 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.**

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

[3] The 10 covered Services limit does not apply.

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**.

**Questions? Call Customer Service** at 1-866-616-0047 (M-F, 8 am-6 pm) or visit **kp.org.**
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 Customer Service. In the case of a conflict between this summary and the EOC, the EOC will prevail.

| **Pediatric Dental**<br>(covered until the end of the month in which Member turns 19 years of age) | **In-network benefit (reimbursement is based on MAC)** | **Out-of-network benefit (reimbursement is based on UCC)** [4] |
|---|---|---|
| **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 | 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 and related 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** | **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 |

[4] "UCC" means Usual and Customary Charge. "MAC" means Maximum Allowable Charge. See your Evidence of Coverage (EOC) for more details.

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