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 Bronze 7000/50 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)	$7,000
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$7,000
Family Deductible per Year (for an entire Family)	$14,000
Out-of-Pocket Maximum *	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$8,550
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$8,550
Family Out-of-Pocket Maximum per Year (for an entire Family)	$17,100
Office visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0
Primary Care	$50
Specialty Care	$60 after Deductible
Naturopathic Medicine (up to 6 visits per Year)	$60 after Deductible per visit
Urgent Care	35% Coinsurance after Deductible
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	35% Coinsurance after Deductible
CT, MRI, PET scans	35% Coinsurance after Deductible
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30-day supply)	$30 generic / $60 after brand Deductible preferred brand / 50% after brand Deductible non-preferred brand / 50% after brand Deductible specialty $1000 brand drug Deductible
Mail Order Prescription drugs (up to a 90-day supply)	$60 generic / $120 after brand Deductible preferred brand / 50% after brand Deductible non-preferred brand / 50% after brand Deductible specialty $1000 brand drug Deductible
Administered medications, including injections (all outpatient settings)	35% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10

Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	35% Coinsurance after Deductible
Inpatient Hospital Services	35% Coinsurance after Deductible
Hospital Services	**You pay**
Ambulance Services (per transport)	35% Coinsurance after Deductible
Emergency services	35% Coinsurance after Deductible
Inpatient Hospital Services	35% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	35% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$60 after Deductible
Durable medical equipment	35% Coinsurance after Deductible
Physical, speech, and occupational therapies (25 visits per therapy/combined per Year)	$60 after Deductible
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 60 days per Year)	35% Coinsurance after Deductible
Chemical Dependency Services	**You pay**
Outpatient Services	$50 per visit
Inpatient hospital & residential Services	35% Coinsurance after Deductible
Mental Health Services	**You pay**
Outpatient Services	$50 per visit
Inpatient hospital & residential Services	35% 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)	$60 after Deductible per visit
Chiropractic Services (up to 10 visits per Year)	$60 after Deductible per visit
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.)	$50
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.

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	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

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

*" 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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