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

KP OR Bronze 7000/60 KP Plus w/VX & Massage

2024 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 [1]		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$9,450	Not applicable
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$9,450	Not applicable
Family Out-of-Pocket Maximum per Year (for an entire Family)	$18,900	Not applicable

	In-Network	Out-of-Network [2] (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	$5 for first 3 visits; then $60 for additional visits in the same Year *	$80
Specialty Care	$80 after Deductible	$100
Urgent Care	40% Coinsurance after Deductible	Not covered, except for Services received outside the Service Area [3]

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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 / $100 preferred brand / 50% Coinsurance after Deductible non-preferred brand / 50% Coinsurance after Deductible specialty	$50 generic / $120 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 / $200 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 visit	$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	$80 after Deductible	Not covered
Durable medical equipment	40% Coinsurance after Deductible	Not covered
Physical, speech, and occupational therapies (30 visits combined per Year)	$80 after Deductible	$100
Skilled Nursing Facility Services	**You pay**	
Inpatient skilled nursing services (up to 60 days per Year)	40% Coinsurance after Deductible	Not covered

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Mental Health and Substance Use Disorder Services	**You pay**	
Outpatient Services	$5 for first 3 visits; then $60 per visit for additional visits in the same Year *	$80 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)	$25 per visit	$45 per visit
Chiropractic Services (up to 20 visits per Year)	$25 per visit	$45 per visit
Massage Therapy (up to 12 visits per Year)	$25 per visit	Not covered
Naturopathic Medicine	$5 for first 3 visits; then $60 for additional visits in the same Year *	$80
Vision Services	**You pay**	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0	$80
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	No charge for one pair standard frames and lenses or 6-month supply contact lenses per year.	Not covered
Routine eye exam (For members 19 years and older.)	$60	$80
Vision hardware and optical Services (For members 19 years and older.)	Balance after $200 allowance in a two-Year period.	Not covered

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

[2] 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.**

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

***** First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, mental health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services received In-Network.

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.

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