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 WA Bronze 7100/0% HSA

2024 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)	$7,100
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$7,100
Family Deductible per Year (for an entire Family)	$14,200
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$7,100
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$7,100
Family Out-of-Pocket Maximum per Year (for an entire Family)	$14,200
Office Visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0 after Deductible
Primary Care	$0 after Deductible
Specialty Care	$0 after Deductible
Urgent Care	$0 after Deductible
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$0 after Deductible per department visit
X-ray, imaging, and special diagnostic procedures	$0 after Deductible per department visit
CT, MRI, PET scans	$0 after Deductible per department visit
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30-day supply)	After Deductible: $0 generic / $0 preferred brand / $0 non-preferred brand / $0 specialty
Mail Order Prescription drugs (up to a 90-day supply)	After Deductible: $0 generic / $0 preferred brand / $0 non-preferred brand
Administered medications, including injections (all outpatient settings)	$0 after Deductible
Nurse treatment room visits to receive injections	$0 after Deductible
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	$0 after Deductible per department visit
X-ray, imaging, and special diagnostic procedures	$0 after Deductible per department visit
Inpatient Hospital Services	$0 after Deductible
Hospital Services	**You pay**
Ambulance Services (per transport)	$0 after Deductible
Emergency services	$0 after Deductible
Inpatient Hospital Services	$0 after Deductible

Outpatient Services (other)	**You pay**
Outpatient surgery visit	$0 after Deductible
Chemotherapy/radiation therapy visit	$0 after Deductible
Durable medical equipment	$0 after Deductible
Physical, speech, and occupational therapies (25 visits per Year)	$0 after Deductible
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 60 days per Year)	$0 after Deductible
Mental Health and Substance Use Disorder Services	**You pay**
Outpatient Services	$0 per visit after Deductible
Inpatient hospital & residential Services	$0 after Deductible
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$0 per visit after Deductible
Chiropractic Services (up to 10 visits per Year)	$0 per visit after Deductible
Massage Therapy	Not covered
Naturopathic Medicine	$0 after Deductible
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.)	Not covered
Vision hardware and optical Services (For members 19 years and older.)	Not covered

Pediatric Dental (covered until the end of the month in which the Member turns 19 years of age)	**In-network benefit (reimbursement is based on MAC)** [2]	**Out-of-network benefit (reimbursement is based on UCC)** [2]
Preventive and Diagnostic Services (not subject to the Deductible)	**You pay**	
Oral exam, including evaluations and diagnostic exams	$0	$0
Fluoride treatment	$0	$0
Teeth cleaning	$0	$0
Sealants	$0	$0
Space maintainers	$0	$0
X-rays	$0	$0
Minor Restoration Services	**You pay**	
Routine fillings	$0 after Deductible	$0 after Deductible
Simple extractions	$0 after Deductible	$0 after Deductible
Restorations (composite / acrylic and steel)	$0 after Deductible	$0 after Deductible
Oral Surgery Services	**You pay**	
Major oral surgery	$0 after Deductible	$0 after Deductible
Surgical tooth extractions	$0 after Deductible	$0 after Deductible
Periodontics	**You pay**	
Scaling and root planing	$0 after Deductible	$0 after Deductible
Treatment of gum disease	$0 after Deductible	$0 after Deductible
Endodontics	**You pay**	
Root canal and related therapy	$0 after Deductible	$0 after Deductible

Major Restoration Services	**You pay**	
Bridges abutments	$0 after Deductible	$0 after Deductible
Noble metal gold or porcelain crowns	$0 after Deductible	$0 after Deductible
Inlays & Pontics	$0 after Deductible	$0 after Deductible
Removable Prosthetic Services	**You pay**	
Full upper and lower dentures	$0 after Deductible	$0 after Deductible
Partial dentures	$0 after Deductible	$0 after Deductible
Rebases	$0 after Deductible	$0 after Deductible
Relines	$0 after Deductible	$0 after Deductible
Emergency Dental Care or Urgent Dental Care	The Cost Share that normally applies for non-emergency dental care Services	
Other Dental Services (not subject to the Deductible)	**You pay**	
Nightguards	$0 after Deductible	$0 after Deductible
Nitrous oxide		
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

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

[2] "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 **kp.org/plandocuments**.

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.**

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, 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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.