

# 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 Silver 3000/45 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.

	In-Network	Out-of-Network
Self-only Deductible per Year (for a Family of one Member)	\$3,000	Not applicable
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$3,000	Not applicable
Family Deductible per Year (for an entire Family)	\$6,000	Not applicable

**Out-of-Pocket Maximum <sup>1</sup>**

	In-Network	Out-of-Network
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$8,900	Not applicable
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$8,900	Not applicable
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$17,800	Not applicable

**In-Network**

**Out-of-Network <sup>2</sup>**  
(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.

<b>Office Visits</b>	<b>You pay</b>	
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 \$45 for additional visits in the same Year *	\$65
Specialty Care	\$55	\$75
Urgent Care	\$65	Not covered, except for Services received outside the Service Area <sup>3</sup>

<b>Tests (outpatient)</b>		<b>You pay</b>	
Preventive Tests	\$0	\$0	
Laboratory	\$45 per department visit	\$65 per department visit	
X-ray, imaging, and special diagnostic procedures	\$50 per department visit	\$70 per department visit	
CT, MRI, PET scans	40% Coinsurance after Deductible	Not covered	
<b>Medications (outpatient)</b>		<b>You pay</b>	
Prescription drugs (up to a 30-day supply)	\$30 generic / \$60 preferred brand / 50% coinsurance 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) <sup>3</sup>	
Mail Order Prescription drugs (up to a 90-day supply)	\$60 generic / \$120 preferred brand / 50% Coinsurance 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	
<b>Maternity Care</b>		<b>You pay</b>	
Scheduled prenatal care visits and postpartum visit	\$0	\$0	
Laboratory	\$45 per department visit	\$65 per department visit	
X-ray, imaging, and special diagnostic procedures	\$45 per department visit	\$65 per department visit	
Inpatient Hospital Services	40% Coinsurance after Deductible	Not covered	
<b>Hospital Services</b>		<b>You pay</b>	
Ambulance Services (per transport)	40% Coinsurance after Deductible	Covered In-Network <sup>3</sup>	
Emergency services	40% Coinsurance after Deductible	Covered In-Network <sup>3</sup>	
Inpatient Hospital Services	40% Coinsurance after Deductible	Not covered	
<b>Outpatient Services (other)</b>		<b>You pay</b>	
Outpatient surgery visit	40% Coinsurance after Deductible	Not covered	
Chemotherapy/radiation therapy visit	\$55	Not covered	
Durable medical equipment	40% Coinsurance after Deductible	Not covered	
Physical, speech, and occupational therapies (30 visits combined per Year)	\$55	\$75	
<b>Skilled Nursing Facility Services</b>		<b>You pay</b>	
Inpatient skilled nursing Services (up to 60 days per Year)	40% Coinsurance after Deductible	Not covered	
<b>Mental Health and Substance Use Disorder Services</b>		<b>You pay</b>	
Outpatient Services	\$5 for first 3 visits; then \$45 per visit for additional visits in the same Year *	\$65 per visit	
Inpatient hospital & residential Services	40% Coinsurance after Deductible	Not covered	

<b>Alternative Care (self-referred)</b>		<b>You pay</b>
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 \$45 for additional visits in the same Year *	\$65

  

<b>Vision Services</b>		<b>You pay</b>
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	\$0	\$65
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.)	\$45	\$65
Vision hardware and optical Services (For members 19 years and older.)	Balance after \$200 allowance in a two-Year period.	Not covered

<sup>1</sup> Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

<sup>2</sup> 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>.

<sup>3</sup> 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](https://kp.org/plandocuments).

**Questions? Call Customer Service** at 1-866-616-0047 (M-F, 8 am-6 pm) or visit [kp.org](https://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.