

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

Oregon PPO PLUS PLAN WDB 500/20%/2500

1/1/2024 - 12/31/2024

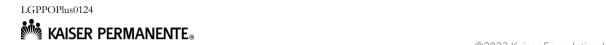
	PPO Providers	Non-Participating Providers
Calendar year is the time period (Year) in which dollar, o accumulate.	day, and visit limits, Deductibles	and Out-of-Pocket Maximums
Deductible For Services that are subject to the Deducti Providers do not count toward the Deductible for Service		
Self-only Deductible per Year (for a Family of one Member)	\$500	\$750
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$500	\$750
Family Deductible per Year (for an entire Family)	\$1,500	\$2,250
Out-of-Pocket Maximum ²		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$2,500	\$3,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$2,500	\$3,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$7,500	\$10,500
Office Visits	Yo	u pay
Routine preventive physical exam	\$0	35% Coinsurance after Deductible
Telehealth (phone/video)	\$0 *	35% Coinsurance after Deductible
Primary Care	\$5 for the first 3 visits; then \$30 for additional visits in the same Year *	35% Coinsurance after Deductible
Specialty Care	\$40	35% Coinsurance after Deductible
Urgent Care	\$50	35% Coinsurance after Deductible
Tests (outpatient)	Yo	u pay
Preventive Tests	\$0	35% Coinsurance after Deductible
Laboratory	\$30 per department visit	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	\$30 per department visit	35% Coinsurance after Deductible
CT, MRI, PET scans	20% Coinsurance after	35% Coinsurance after

Deductible

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Deductible

Medications (outpatient)	You pay	
Prescription drugs (up to a 30-day supply)	Rider Available for Purchase	
Mail Order Prescription drugs		
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Nurse treatment room visits to receive injections	\$30	35% Coinsurance after Deductible
Maternity Care	You	и рау
Scheduled prenatal care visits and postpartum visits	\$0	35% Coinsurance after Deductible
Laboratory	\$30 per department visit	35% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	\$30 per department visit	35% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Hospital Services	You pay	
Ambulance Services (per transport)	10% Coinsurance after Deductible	
Emergency services	\$200 after Deductible (Waived if admitted)	
Inpatient Hospital Services	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Outpatient Services (other)	You	и рау
Outpatient surgery visit	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Durable medical equipment	30% Coinsurance after Deductible	35% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Skilled Nursing Facility Services	You	и рау
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	You	u pay
Outpatient Services	\$5 for the first 3 visits; then \$30 per visit for additional visits in the same Year *	35% Coinsurance after Deductible
Inpatient hospital & residential Services	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Alternative Care	You pay	
Acupuncture Services	Rider Availab	le for Purchase
Chiropractic Services		
Massage Therapy		
Naturopathic Medicine	\$5 for the first 3 visits; then \$30 for additional visits in the same Year *	35% Coinsurance after Deductible



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Vision Services	You pay	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	\$30	35% Coinsurance after Deductible
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	Rider Available for Purchase	
Routine eye exam (For members 19 years and older.)	\$30	35% Coinsurance after Deductible
Vision hardware and optical Services (For members 19 years and older.)	Rider Available for Purchase	

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 PPO hospital or ambulatory surgical center. For additional information, visit https://healthy.kaiserpermanente.org/oregon-washington/support/pay-bills/medical-bills/no-surprises-act.

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

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

^{*} 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 from PPO Providers.