

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 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

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|--|----------|
| 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

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|---|---|
| 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

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|--|---|
| 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

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| 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 |

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|--|--|
| 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 (30 visits combined 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 20 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 one pair standard frames and lenses or 6-month supply contact lenses per year. |
| Routine eye exam (For members 19 years and older.) | Not covered |
| Vision hardware and optical Services (For members 19 years and older.) | Not covered |

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

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.