

# 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 w/VX & Massage**

**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 <sup>1</sup>

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

<b>Hospital Services</b>	<b>You pay</b>
Ambulance Services (per transport)	\$0 after Deductible
Emergency services	\$0 after Deductible
Inpatient Hospital Services	\$0 after Deductible
<b>Outpatient Services (other)</b>	<b>You pay</b>
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
<b>Skilled Nursing Facility Services</b>	<b>You pay</b>
Inpatient skilled nursing Services (up to 60 days per Year)	\$0 after Deductible
<b>Mental Health and Substance Use Disorder Services</b>	<b>You pay</b>
Outpatient Services	\$0 per visit after Deductible
Inpatient Hospital & residential Services	\$0 after Deductible
<b>Alternative Care</b> (self-referred)	<b>You pay</b>
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 (up to 12 visits per Year)	\$0 per visit after Deductible
Naturopathic Medicine	\$0 after Deductible
<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
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.)	\$0 after Deductible
Vision hardware and optical Services (For members 19 years and older.)	Balance after \$200 allowance in a two-Year period.

<sup>1</sup> 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.