

## **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 Platinum 0/20 KP Plus

2024 Contract

	In-Network	Out-of-Network
Calendar year is the time period (Year) in which dollar, day, accumulate.	and visit limits, Deductibles	and Out-of-Pocket Maximums
<b>Deductible</b> Services that are subject to the Deductible are i Cost Share amount shown in this summary.	ndicated below. After you me	eet your Deductible, you pay the
Self-only Deductible per Year (for a Family of one Member)	None	Not applicable
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	None	Not applicable
Family Deductible per Year (for an entire Family)	None	Not applicable
Out-of-Pocket Maximum 1		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$2,200	Not applicable
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$2,200	Not applicable
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$4,400	Not applicable

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.

**In-Network** 

Office Visits		You pay	
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 \$20 for additional visits in the same Year *	\$40	
Specialty Care	\$30	\$50	
Urgent Care	\$40	Not covered, except for Services received outside the Service Area <sup>3</sup>	

Out-of-Network<sup>2</sup>

(Limited to 10 covered

Preventive Tests   \$0	Tests (outpatient)	(outpatient) You pay		
X-ray, imaging, and special diagnostic procedures  CT, MRI, PET scans  Prescription drugs (up to a 30-day supply)  Prescription drugs (up to a 30-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Administered medications, including injections (all outpatient settings)  Nurse treatment room visits to receive injections  Scheduled prenatal care visits and postpartum visits  Laboratory  Scheduled prenatal care visits and postpartum visits  Scheduled prenatal care visits and postpartum visits  Not covered  Scheduled prenatal care visits and postpartum visits  Not covered  Scheduled prenatal visit  Schedul	Preventive Tests	\$0	\$0	
CT, MRI, PET scans   \$75 per department visit   Not covered   Medications (outpatient)   You pay   \$25 generic / \$15 preferred brand / \$50 non-preferred brand / \$50 presents of \$50 pre admission / \$50 non-preferred brand / \$	Laboratory	\$20 per department visit	\$40 per department visit	
Prescription drugs (up to a 30-day supply)  Prescription drugs (up to a 30-day supply)  Prescription drugs (up to a 30-day supply)  Specialty  Wall Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Administered medications, including injections (all outpatient settings)  Nurse treatment room visits to receive injections  Asternity Care  Scheduled prenatal care visits and postpartum visits  Laboratory  Scheduled prenatal care visits and postpartum visits  Naternity Care  Scheduled prenatal care visits and postpartum visits  Naternity Care  Scheduled prenatal care visits and postpartum visits  Naternity Care  Scheduled prenatal care visits and postpartum visits  Naternity Care  Scheduled prenatal care visits and postpartum visits  Naternity Care  Scheduled prenatal care visits and postpartum visits  So per department visit  Salo per department visit  Salo per department visit  Spo per	X-ray, imaging, and special diagnostic procedures	\$30 per department visit	\$50 per department visit	
Prescription drugs (up to a 30-day supply)  \$5 generic / \$15 preferred brand / \$50 non-preferred brand / 50% Coinsurance specialty  Mail Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Administered medications, including injections (all outpatient settings)  Nurse treatment room visits to receive injections  Scheduled prenatal care visits and postpartum visits  Scheduled prenatal care visits and postpartum visits  Laboratory  Scheduled prenatal care visits and postpartum visits  Laboratory  Scheduled prenatal care visits and postpartum visits  Inpatient Hospital Services  Ambulance Services (per transport)  Emergency services (per transport)  Emergency services  Solo per day up to \$1,500  per admission  You pay  Outpatient Services (other)  Outpatient Surgery visit  Chemotherapy/radiation therapy visit  Solo per day up to \$1,500  per admission  You pay  Outpatient surgery visit  Solo per day up to \$1,500  Por day up to \$1,500  Por day up to \$1,500  Not covered  Not covered  Not covered  Not covered  Durable medical equipment  Solo per day up to \$1,500  Por day up to \$1,500  Por day up to \$1,500  Not covered  Chemotherapy/radiation therapy visit  Solo per day up to \$1,500  Por day  Outpatient Services (other)  Outpatient Services (other)  Solo per day up to \$1,500  Por day  Outpatient Services (other)  Solo per day up to \$1,500  Por day  Outpatient Services (other)  Solo per day up to \$1,500  Not covered  Not covered  Not covered  Not covered  Not covered  Solo per day up to \$1,500  Por day  Not covered  Solo per day up to \$1,500  Por day  Solo per day up to \$1,500  Por admission  Not covered  Solo per admission  Not covered  Not covered  Solo per admission  Not co	CT, MRI, PET scans	\$75 per department visit	Not covered	
brand / \$50 non-preferred brand / 50% Coinsurance specialty  Mail Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Administered medications, including injections (all outpatient settings)  Nurse treatment room visits to receive injections  Murse treatment room visits to receive injections  S10  \$30  Maternity Care  Scheduled prenatal care visits and postpartum visits  Laboratory  Scheduled prenatal care visits and postpartum visits  S20  S0  Laboratory  S20 per department visit  \$40 per department visit  Inpatient Hospital Services  Ambulance Services (per transport)  Emergency services  Inpatient Hospital Services  S150 (Waived if admitted)  Covered In-Network 3  Emergency services (other)  Outpatient Services (other)  Outpatient Services (other)  Outpatient surgery visit  S100  Not covered  Chemotherapy/radiation therapy visit  S100  Not covered  Physical, speech, and occupational therapies (30 visits combined per Year)  Inpatient skilled nursing Services (up to 60 days per Year)  Stilled Nursing Facility Services  Vou pay  Inpatient skilled nursing Services (up to 60 days per year)  S500 per day up to \$1,500  Not covered  Physical, speech, and occupational therapies (30 visits combined per Year)  Storms Ambulance Services  Vou pay  Inpatient skilled nursing Services (up to 60 days per year)  S500 per day up to \$1,500  Not covered  S400 per admission  Not covered  S500 per day up to \$1,500  Not covered  S600  Not covered  S600  Not covered  S600  Not covered	Medications (outpatient)	Yo	ou pay	
Mail Order Prescription drugs (up to a 90-day supply)  Mail Order Prescription drugs (up to a 90-day supply)  Administered medications, including injections (all outpatient settings)  Nurse treatment room visits to receive injections  State of the stat	Prescription drugs (up to a 30-day supply)	brand / \$50 non-preferred brand / 50% Coinsurance	brand / 50% Coinsurance Specialty	
Administered medications, including injections (all outpatient settings)  Nurse treatment room visits to receive injections  Scheduled prenatal care visits and postpartum visits  Scheduled Irish prenatal care visits and postpartum visit and admitted Irish prenatal care visit and visits a				
outpatient settings) Nurse treatment room visits to receive injections  **Maternity Care**  Scheduled prenatal care visits and postpartum visits Laboratory  Scheduled prenatal care visits and postpartum visits  **X-ray, imaging, and special diagnostic procedures Inpatient Hospital Services  **Soper department visit  **Soper day up to \$1,500  Povered In-Network 3  **Covered In-Network 3  **Inpatient Hospital Services  **Outpatient Services (other)  **Out	Mail Order Prescription drugs (up to a 90-day supply)	brand / \$100 non-preferred	Not covered	
Scheduled prenatal care visits and postpartum visits  Laboratory  Scheduled prenatal care visits and postpartum visits  Laboratory  X-ray, imaging, and special diagnostic procedures  Inpatient Hospital Services  Sa00 per department visit  S50 per depar		20% Coinsurance	Not covered	
Scheduled prenatal care visits and postpartum visits  Laboratory  Laboratory  \$20 per department visit  X-ray, imaging, and special diagnostic procedures  \$30 per department visit  \$50 per department visit  X-ray, imaging, and special diagnostic procedures  \$300 per day up to \$1,500 per department visit  Not covered  Not covered  Not covered In-Network 3  Emergency services  Inpatient Hospital Services  \$150 (Waived if admitted)  Covered In-Network 3  Inpatient Hospital Services  \$300 per day up to \$1,500 covered In-Network 3  Inpatient Hospital Services  \$300 per day up to \$1,500 Not covered  Poutpatient Services (other)  You pay  Outpatient Services (other)  Outpatient surgery visit  \$100 Not covered  Chemotherapy/radiation therapy visit  \$30 Not covered  Durable medical equipment  Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services  Inpatient skilled nursing Services (up to 60 days per Year)  Skilled Nursing Facility Services  Outpatient Services  Outpatient Services  Outpatient Services  Pou pay  Outpatient Services  You pay  Outpatient Health and Substance Use Disorder Services  For first 3 visits; then \$20 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500 Not covered  \$40 per visit in the same Year *	Nurse treatment room visits to receive injections	\$10	\$30	
Laboratory \$20 per department visit \$40 per department visit X-ray, imaging, and special diagnostic procedures \$30 per department visit \$50 per department visit Inpatient Hospital Services \$300 per day up to \$1,500 per admission  Hospital Services You pay  Ambulance Services (per transport) \$150 Covered In-Network 3 Emergency services \$150 (Waived if admitted) Covered In-Network 3 Inpatient Hospital Services \$300 per day up to \$1,500 per admission  Outpatient Services (other) You pay  Outpatient Services (other) You pay  Outpatient surgery visit \$100 Not covered Chemotherapy/radiation therapy visit \$30 Not covered Durable medical equipment \$20% Coinsurance Not covered Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services \$300 per day up to \$1,500 Not covered Private of the per admission Not covered Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services Services (up to \$300 per day up to \$1,500 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services \$300 per day up to \$1,500 Not covered	Maternity Care	You pay		
X-ray, imaging, and special diagnostic procedures  Inpatient Hospital Services  Sand per day up to \$1,500 per department visit  Not covered  Not covered In-Network 3  Not covered  Solupatient skilled nursing Services (up to 60 days per Year)  Not covered	Scheduled prenatal care visits and postpartum visits	\$0	\$0	
Inpatient Hospital Services  Hospital Services  Ambulance Services (per transport)  Emergency services  Inpatient Hospital Services  State of the services (per transport)  Emergency services  Inpatient Hospital Services  State of the services (per transport)  Emergency services  Inpatient Hospital Services  State of the services (per transport)  Inpatient Hospital Services  State of the services (per transport)  Emergency services  State of the services (per transport)  State of the services (per damission (per admission (	Laboratory	\$20 per department visit	\$40 per department visit	
Ambulance Services (per transport)  Emergency services  Inpatient Hospital Services  Outpatient Services (other)  Outpatient Surgery visit  Chemotherapy/radiation therapy visit  Durable medical equipment  Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services  Outpatient Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services  Inpatient Hospital & Residential Services  You pay  Outpatient Services  You pay  Not covered  Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services  You pay  Outpatient skilled nursing Services (up to 60 days per Year)  Stripatient Services  You pay  Not covered	X-ray, imaging, and special diagnostic procedures	\$30 per department visit	\$50 per department visit	
Ambulance Services (per transport)  Emergency services  Inpatient Hospital Services  Inpatient Services  Sand per day up to \$1,500 per admission  Not covered In-Network 3  Not covered In-Network 4  Not covered In-Network 1  No	Inpatient Hospital Services		Not covered	
Emergency services \$150 (Waived if admitted) Covered In-Network 3 Inpatient Hospital Services \$300 per day up to \$1,500 per admission  Outpatient Services (other) You pay  Outpatient surgery visit \$100 Not covered Chemotherapy/radiation therapy visit \$30 Not covered Durable medical equipment 20% Coinsurance Not covered Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services You pay  Inpatient skilled nursing Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services You pay  Outpatient Services \$50 Not covered \$50 per admission  Mental Health and Substance Use Disorder Services You pay  Outpatient Services \$50 Services You pay  Inpatient Hospital & Residential Services \$300 per day up to \$1,500 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services \$300 per day up to \$1,500 Not covered	Hospital Services			
Inpatient Hospital Services \$300 per day up to \$1,500 per admission  Outpatient Services (other)  Outpatient surgery visit  Chemotherapy/radiation therapy visit  Durable medical equipment  Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services  Inpatient skilled nursing Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services  Unpatient Services  \$300 per day up to \$1,500 per admission  You pay  Specially Services  You pay  Outpatient Services  You pay  Outpatient Services  You pay  Outpatient Services  You pay  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500  Not covered	Ambulance Services (per transport)	\$150	Covered In-Network <sup>3</sup>	
Dutpatient Services (other)  Outpatient surgery visit  Chemotherapy/radiation therapy visit  Durable medical equipment  Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services  Inpatient skilled nursing Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services  Unpatient Services  Storman  Structure for additional visits in the same Year *  Inpatient Hospital & Residential Services  Storman  You pay  Storman  Not covered  You pay  Storman  Not covered  You pay  Storman  Not covered  Storman  S	Emergency services	\$150 (Waived if admitted)	Covered In-Network <sup>3</sup>	
Outpatient surgery visit \$100 Not covered Chemotherapy/radiation therapy visit \$30 Not covered Durable medical equipment 20% Coinsurance Not covered Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services You pay Inpatient skilled nursing Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services  Outpatient Services  \$50 Not covered \$300 per day up to \$1,500 per admission  Not covered  You pay  Outpatient Services  \$5 for first 3 visits; then \$20 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500  Not covered	Inpatient Hospital Services		Not covered	
Chemotherapy/radiation therapy visit \$30 Not covered  Durable medical equipment 20% Coinsurance Not covered  Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services You pay  Inpatient skilled nursing Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services  Outpatient Services  Stor first 3 visits; then \$20 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500 Not covered  \$40 per visit  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500 Not covered	Outpatient Services (other)			
Durable medical equipment  Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services  Inpatient skilled nursing Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services  Outpatient Services  Fou pay  You pay  Outpatient Services  Outpatient Services  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500 per admission  Not covered  \$5 for first 3 visits; then \$20 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500  Not covered	Outpatient surgery visit	\$100	Not covered	
Physical, speech, and occupational therapies (30 visits combined per Year)  Skilled Nursing Facility Services  Inpatient skilled nursing Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services  Outpatient Services  Stor first 3 visits; then \$20 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500 Not covered  \$40 per visit in the same Year *	Chemotherapy/radiation therapy visit	\$30	Not covered	
Combined per Year)  Skilled Nursing Facility Services  Inpatient skilled nursing Services (up to 60 days per Year)  Mental Health and Substance Use Disorder Services  Outpatient Services  Stor first 3 visits; then \$20 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services  Syou pay  \$5 for first 3 visits; then \$20 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services  \$300 per day up to \$1,500  Not covered	Durable medical equipment	20% Coinsurance	Not covered	
Skilled Nursing Facility Services   You pay		\$30	\$50	
Inpatient skilled nursing Services (up to 60 days per Year)    Same state of the st	·	Yo	ou pay	
Outpatient Services \$5 for first 3 visits; then \$20 per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services \$300 per day up to \$1,500 Not covered	Inpatient skilled nursing Services (up to 60 days per	\$300 per day up to \$1,500		
per visit for additional visits in the same Year *  Inpatient Hospital & Residential Services \$300 per day up to \$1,500 Not covered	Mental Health and Substance Use Disorder Services	Yo	ou pay	
	Outpatient Services	per visit for additional visits	\$40 per visit	
	Inpatient Hospital & Residential Services		Not covered	

Alternative Care (self-referred)	You pay	
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	Not covered	Not covered
Naturopathic Medicine	\$5 for first 3 visits; then \$20 for additional visits in the same Year *	\$40
Vision Services	You p	pay
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	\$0	\$40
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.)	Not covered	Not covered
Vision hardware and optical Services (For members 19 years and older.)	Not covered	Not covered

<sup>&</sup>lt;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**.

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 Customer Service. In the case of a conflict between this summary and the EOC, the EOC will prevail.

<sup>&</sup>lt;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>&</sup>lt;sup>3</sup> The 10 covered Services limit does not apply.

<sup>\*</sup> 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.