

Summary of Medical Benefits

KP WA Bronze 7000

2025 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)	\$7,000
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$7,000
Family Deductible per Year (for an entire Family)	\$14,000

Out-of-Pocket Maximum ¹

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$9,200
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$9,200
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$18,400

Office Visits

You pay

Routine preventive physical exam	\$0
Telehealth (phone/video)	\$0
Primary Care	\$50
Specialty Care	\$70 after Deductible
Urgent Care	40% Coinsurance after Deductible

Tests (outpatient)

You pay

Preventive Tests	\$0
Laboratory	40% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	40% Coinsurance after Deductible
CT, MRI, PET scans	40% Coinsurance after Deductible

Medications (outpatient)

You pay

Prescription drugs (up to a 30-day supply)	\$35 generic / \$60 preferred brand / 50% Coinsurance after Deductible non-preferred brand / 50% Coinsurance after Deductible specialty
Mail Order Prescription drugs (up to a 90-day supply)	\$70 generic / \$120 preferred brand / 50% Coinsurance after Deductible non-preferred brand
Administered medications, including injections (all outpatient settings)	40% Coinsurance after Deductible
Nurse treatment room visits to receive injections	\$10

Maternity Care

You pay

Scheduled prenatal care visits and postpartum visits	\$0
Laboratory	40% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	40% Coinsurance after Deductible
Inpatient Hospital Services	40% Coinsurance after Deductible

Hospital Services		You pay
Ambulance Services (per transport)		40% Coinsurance after Deductible
Emergency services		40% Coinsurance after Deductible
Inpatient Hospital Services		40% Coinsurance after Deductible
Outpatient Services (other)		You pay
Outpatient surgery visit		40% Coinsurance after Deductible
Chemotherapy/radiation therapy visit		\$70 after Deductible
Durable medical equipment		40% Coinsurance after Deductible
Physical, speech, and occupational therapies (25 visits per Year)		\$70 after Deductible
Skilled Nursing Facility Services		You pay
Inpatient skilled nursing Services (up to 60 days per Year)		40% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services		You pay
Outpatient Services		\$50 per visit
Inpatient hospital & residential Services		40% Coinsurance after Deductible
Alternative Care (self-referred)		You pay
Acupuncture Services (up to 12 visits per Year)		\$70 per visit after Deductible
Chiropractic Services (up to 10 visits per Year)		\$70 per visit after Deductible
Massage Therapy		Not covered
Naturopathic Medicine		\$50
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 eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)		Not covered
Vision hardware and optical Services (For members 19 years and older.)		Not covered

Pediatric Dental (covered until the end of the month in which the Member turns 19 years of age)		In-network benefit (reimbursement is based on MAC) ²	Out-of-network benefit (reimbursement is based on UCC) ²
Preventive and Diagnostic Services (not subject to the Deductible)		You pay	
Oral exam, including evaluations and diagnostic exams		\$0	\$0
Fluoride treatment		\$0	\$0
Teeth cleaning		\$0	\$0
Sealants		\$0	\$0
Space maintainers		\$0	\$0
X-rays		\$0	\$0
Minor Restoration Services		You pay	
Routine fillings		50% Coinsurance	50% Coinsurance
Simple extractions		50% Coinsurance	50% Coinsurance
Restorations (composite / acrylic and steel)		50% Coinsurance	50% Coinsurance
Oral Surgery Services		You pay	
Major oral surgery		50% Coinsurance	50% Coinsurance
Surgical tooth extractions		50% Coinsurance	50% Coinsurance
Periodontics		You pay	
Scaling and root planing		50% Coinsurance	50% Coinsurance
Treatment of gum disease		50% Coinsurance	50% Coinsurance

Pediatric Dental (covered until the end of the month in which the Member turns 19 years of age)		In-network benefit (reimbursement is based on MAC) ²	Out-of-network benefit (reimbursement is based on UCC) ²
Endodontics		You pay	
Root canal and related therapy		50% Coinsurance	50% Coinsurance
Major Restoration Services		You pay	
Bridges abutments		50% Coinsurance	50% Coinsurance
Noble metal gold or porcelain crowns		50% Coinsurance	50% Coinsurance
Inlays & Pontics		50% Coinsurance	50% Coinsurance
Removable Prosthetic Services		You pay	
Full upper and lower dentures		50% Coinsurance	50% Coinsurance
Partial dentures		50% Coinsurance	50% Coinsurance
Rebases		50% Coinsurance	50% Coinsurance
Relines		50% Coinsurance	50% Coinsurance
Emergency Dental Care or Urgent Dental Care		The Cost Share that normally applies for non-emergency dental care Services	
Other Dental Services (not subject to the Deductible)		You pay	
Nightguards (limit one every five years)		35% Coinsurance	35% Coinsurance
Nitrous oxide			
Adults and children age 13 years and older		\$25	\$25
Children age 12 years and younger		\$25	\$25
Orthodontics (medically necessary, diagnosis of cleft palate/lip)		50% Coinsurance	50% Coinsurance

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

² "UCC" means Usual and Customary Charge. "MAC" means Maximum Allowable Charge. See your Evidence of Coverage (EOC) for more details.

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.