All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of Medical Benefits

KP WA Bronze 9200 w/VX

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)	$9,200
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$9,200
Family Deductible per Year (for an entire Family)	$18,400
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	First three visits per Year at $40 not subject to the Deductible, remaining visits at $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)	$30 generic; After Deductible: $0 preferred brand, non-preferred brand and specialty
Mail Order Prescription drugs (up to a 90-day supply)	$60 generic; After Deductible: $0 preferred brand, non-preferred brand
Administered medications, including injections (all outpatient settings)	$0 after Deductible
Nurse treatment room visits to receive injections	$10
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

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 (25 visits 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 10 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 eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)	$40
Vision hardware and optical Services (For members 19 years and older.)	Balance after $250 allowance in a two-Year period.

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.

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