KAISER PERMANENTE®

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 OR Gold Added Choice 1500 w/VX & Massage

2027 Contract

Calendar year is the time period (year) in which dollar, day, and visit limits, deductibles, and out-of-pocket maximums accumulate.

Deductible

For services that are subject to the deductible, the amounts you pay for covered services from select providers also count toward the deductible for services from PPO providers, and vice versa. The amounts you pay for services from non-participating providers only count toward the deductible for services from non-participating providers.

	Select providers	PPO providers	Non-participating providers[1]
Self-only deductible per year (for a family of one member)	$1,500	$2,000	$6,000
Individual family member deductible per year (for each member in a family of two or more members)	$1,500	$2,000	$6,000
Family deductible per year (for an entire family)	$3,000	$4,000	$12,000

Out-of-pocket maximum[2]

	Select providers	PPO providers	Non-participating providers[1]
Self-only out-of-pocket maximum per year (for a family of one member)	$8,500	$10,500	$12,000
Individual family member out-of-pocket maximum per year (for each member in a family of two or more members)	$8,500	$10,500	$12,000
Family out-of-pocket maximum per year (for an entire family)	$17,000	$21,000	$24,000

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Medical care

	Select providers You pay	PPO providers You pay	Non-participating providers[1] You pay
Office visits			
Routine preventive physical exam	$0	$0	50% coinsurance after deductible
Telehealth (phone/video)	$0*	$0*	50% coinsurance after deductible
Primary care	$5 for first 3 visits, then $25 for additional visits in the same year*	$5 for the first 3 visits, then $45 for additional visits in the same year*	50% coinsurance after deductible
Specialty care	$50	$70	50% coinsurance after deductible
Urgent care	$60	$80	50% coinsurance after deductible
Tests (outpatient)			
Preventive tests	$0 per department visit	$0 per department visit	50% coinsurance after deductible
Laboratory	$20 per department visit	40% coinsurance after deductible	50% coinsurance after deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	40% coinsurance after deductible	50% coinsurance after deductible
CT, MRI, PET scans	$300 per department visit	40% coinsurance after deductible	50% coinsurance after deductible
Medications (outpatient)			
Prescription drugs (up to a 30-day supply)	$15 generic / $50 preferred brand / 50% coinsurance non-preferred brand / 50% coinsurance specialty	At MedImpact Pharmacy: $30 generic / $75 preferred brand / 50% coinsurance non-preferred brand / 50% coinsurance specialty	At MedImpact Pharmacy: $30 generic / $75 preferred brand / 50% coinsurance non-preferred brand / 50% coinsurance specialty
Mail order prescription drugs (up to a 90-day supply)	$30 generic / $100 preferred brand / 50% coinsurance non-preferred brand	MedImpact Mail-Order: Call CVS Caremark 1-800-237-2767	MedImpact Mail-Order: Call CVS Caremark 1-800-237-2767
Administered medications, including injections (all outpatient settings)	25% coinsurance	40% coinsurance	50% coinsurance after deductible
Nurse treatment room visits to receive injections	$10	$45	50% coinsurance after deductible

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	Select providers You pay	PPO providers You pay	Non-participating providers[1] You pay
Maternity care			
Scheduled prenatal care visits and postpartum visits	$0	$0	50% coinsurance after deductible
Laboratory	$20 per department visit	40% coinsurance after deductible	50% coinsurance after deductible
X-ray, imaging, and special diagnostic procedures	$20 per department visit	40% coinsurance after deductible	50% coinsurance after deductible
Inpatient hospital services	25% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Hospital services			
Ambulance services (per transport)	25% coinsurance after deductible	25% coinsurance after deductible	25% coinsurance after deductible
Emergency services	25% coinsurance after deductible	25% coinsurance after deductible	25% coinsurance after deductible
Inpatient hospital services	25% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Outpatient services (other)			
Outpatient surgery visit	25% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Chemotherapy/radiation therapy visit	$50	$70	50% coinsurance after deductible
Durable medical equipment	25% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Physical, speech, and occupational therapies (30 visits combined per year)	$50	$70	50% coinsurance after deductible
Skilled nursing facility services			
Inpatient skilled nursing services (up to 60 days per year)	25% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
Mental health and substance use disorder services			
Outpatient services	$5 for the first 3 visits, then $25 for additional visits in the same year*	$5 for the first 3 visits, then $45 for additional visits in the same year*	50% coinsurance after deductible
Inpatient hospital & residential services	25% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible

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	Select providers You pay	PPO providers You pay	Non-participating providers[1] You pay
Alternative care			
Acupuncture services (up to 12 visits per year)	$25 per visit	20% coinsurance	40% coinsurance
Chiropractic services (up to 20 visits per year)	$25 per visit	20% coinsurance	40% coinsurance
Massage therapy (up to 12 visits per year)	$25 per visit	20% coinsurance	40% coinsurance
Naturopathic medicine	$5 for the first 3 visits, then $25 for additional visits in the same year*	$5 for the first 3 visits, then $45 for additional visits in the same year*	50% coinsurance after deductible
Vision services			
Routine eye exam (covered until the end of the month in which member turns 19 years of age.)	$0	$0	50% coinsurance after deductible
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.	No charge for one pair standard frames and lenses or 6-month supply contact lenses per year.	50% coinsurance after deductible
Routine eye exam (for members 19 years and older.)	$25	$45	50% coinsurance
Vision hardware and optical services (for members 19 years and older.)	Balance after $250 dollars for allowance per 24 months (calendar).	Balance after $250 dollars for allowance per 24 months (calendar).	Balance after $250 dollars for allowance per 24 months (calendar).

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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)[3] You pay	Out-of-network benefit (reimbursement is based on UCC)[3]Error! Bookmark not defined. You pay
Preventive and diagnostic services		
Oral exam	$0	$0
X-rays	$0	$0
Teeth cleaning	$0	$0
Fluoride	$0	$0
Basic restoration services		
Routine fillings	50% coinsurance	50% coinsurance
Plastic and steel crowns	50% coinsurance	50% coinsurance
Simple extractions	50% coinsurance	50% coinsurance
Oral surgery services		
Surgical tooth extractions	50% coinsurance	50% coinsurance
Periodontics		
Treatment of gum disease	50% coinsurance	50% coinsurance
Scaling and root planing	50% coinsurance	50% coinsurance
Endodontics		
Root canal therapy	50% coinsurance	50% coinsurance
Major restoration services		
Gold or porcelain crowns	50% coinsurance	50% coinsurance
Bridges	50% coinsurance	50% coinsurance
Removable prosthetic services		
Full and partial dentures	50% coinsurance	50% coinsurance
Relines	50% coinsurance	50% coinsurance
Rebases	50% coinsurance	50% coinsurance
Emergency dental care or urgent dental care	The cost share that normally applies for non-emergency dental care services	The cost share that normally applies for non-emergency dental care services
Other dental services (not subject to the deductible)		
Nightguards	35% coinsurance	35% coinsurance
Nitrous oxide	$25	$25
Orthodontics (medically necessary, diagnosis of cleft palate/lip)	50% coinsurance	50% coinsurance

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[1] 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 Select or PPO hospital or ambulatory surgical center. For additional information, visit **https://healthy.kaiserpermanente.org/oregon-washington/support/pay-bills/medical-bills/no-surprises-act**.

[2] Refer to your *Evidence of Coverage (EOC)* for benefits that may not apply to out-of-pocket maximum.

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

***** 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.

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** (Monday through Friday, 8 a.m. to 6 p.m.) 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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

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Nondiscrimination notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).
If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

For Washington Members:
You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

This notice is available at https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice

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Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: **711**)።

العربية(Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電**1-800-813-2000**（TTY：**711**）。

فارسی(Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با**1-800-813-2000** (TTY (تلفن متنی): **711**) تماس بگیرید.

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-813-2000** an (TTY: **711**).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-813-2000**までお電話ください（TTY: **711**）。

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖ បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសម្រួលដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-800-813-2000** (TTY: **711**).

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-813-2000**로 전화해 주세요(TTY: **711**).

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັ້ງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-813-2000** irratti bilbilaa (TTY:- **711**)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- **711**).

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: **711**).