

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

Oregon PPO PLUS HDHP EE PLAN
5000/30%/7000

1/1/2025 - 12/31/2025

PPO Providers Non-Participating Providers ¹

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible (Embedded Accumulation: If two or more family members are enrolled on the plan, each member must meet their own individual deductible or the combined family must meet the overall family deductible, whichever occurs first. After the deductible is met, you pay the applicable copay/coinsurance for the rest of the year until the out-of-pocket maximum is met.)

For Services that are subject to the Deductible, the amounts you pay for covered Services from PPO Providers do not count toward the Deductible for Services from Non-Participating Providers, and vice versa.

Self-only Deductible per Year (for a Family of one Member)	\$5,000	\$7,500
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$5,000	\$7,500
Family Deductible per Year (for an entire Family)	\$10,000	\$15,000

Out-of-Pocket Maximum ² (Embedded Accumulation: If two or more family members are enrolled on the plan, each must meet their own individual out-of-pocket maximum or the combined family must meet the overall family out-of-pocket maximum, whichever occurs first. After the out-of-pocket maximum is met, no copays/coinsurance is required for the rest of the year.)

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$7,000	\$8,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$7,000	\$8,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$14,000	\$17,000

Office Visits

You pay

Routine preventive physical exam	\$0	40% Coinsurance after Deductible
Telehealth (phone/video)	\$0 after Deductible *	40% Coinsurance after Deductible
Primary Care	\$5 after Deductible for the first 3 visits; then 30% Coinsurance after Deductible for additional visits in the same Year *	40% Coinsurance after Deductible
Specialty Care	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care	30% Coinsurance after Deductible	40% Coinsurance after Deductible

Tests (outpatient)		You pay	
Preventive Tests	\$0	40% Coinsurance after Deductible	
Laboratory	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
X-ray, imaging, and special diagnostic procedures	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
CT, MRI, PET scans	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Medications (outpatient)		You pay	
Prescription drugs (up to a 30-day supply)	Rider Available for Purchase		
Mail Order Prescription drugs			
Administered medications, including injections (all outpatient settings)	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Nurse treatment room visits to receive injections	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Maternity Care		You pay	
Scheduled prenatal care visits and postpartum visits	\$0	40% Coinsurance after Deductible	
Laboratory	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
X-ray, imaging, and special diagnostic procedures	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Inpatient Hospital Services	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Hospital Services		You pay	
Ambulance Services (per transport)	30% Coinsurance after Deductible		
Emergency services	30% Coinsurance after Deductible		
Inpatient Hospital Services	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Outpatient Services (other)		You pay	
Outpatient surgery visit	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Chemotherapy/radiation therapy visit	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Durable medical equipment	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Physical, speech, and occupational therapies (20 visits per therapy per Year)	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Skilled Nursing Facility Services		You pay	
Inpatient skilled nursing Services (up to 100 days per Year)	30% Coinsurance after Deductible	40% Coinsurance after Deductible	
Mental Health and Substance Use Disorder Services		You pay	
Outpatient Services	\$5 after Deductible for the first 3 visits; then 30% Coinsurance after Deductible for additional visits in the same Year *	40% Coinsurance after Deductible	
Inpatient hospital & residential Services	30% Coinsurance after Deductible	40% Coinsurance after Deductible	

Alternative Care	You pay	
Acupuncture Services	Rider Available for Purchase	
Chiropractic Services		
Massage Therapy		
Naturopathic Medicine	\$5 after Deductible for the first 3 visits; then 30% Coinsurance after Deductible for additional visits in the same Year *	40% Coinsurance after Deductible

Vision Services	You pay	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	Rider Available for Purchase	
Routine eye exam (For members 19 years and older.)	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Vision hardware and optical Services (For members 19 years and older.)	Rider Available for Purchase	

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 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.

* 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 from PPO Providers.

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 Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.