KAISER PERMANENTE®

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 PLAN WDU 1500/20%/5500 **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 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)	$1,500	$2,250
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$1,500	$2,250
Family Deductible per Year (for an entire Family)	$4,500	$6,750
Out-of-Pocket Maximum [2]		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$5,500	$7,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$5,500	$7,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	$11,000	$15,000
Office Visits	**You pay**	
Routine preventive physical exam	$0	45% Coinsurance after Deductible
Telehealth (phone/video)	$0 *	45% Coinsurance after Deductible
Primary Care	$5 for the first 3 visits; then $25 for additional visits in the same Year *	45% Coinsurance after Deductible
Specialty Care	$35	45% Coinsurance after Deductible
Urgent Care	$45	45% Coinsurance after Deductible
Tests (outpatient)	**You pay**	
Preventive Tests	$0	45% Coinsurance after Deductible
Laboratory	$25 per department visit	45% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$25 per department visit	45% Coinsurance after Deductible
CT, MRI, PET scans	$100 per department visit	45% 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)	20% Coinsurance after Deductible	45% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$25	45% Coinsurance after Deductible
Maternity Care	**You pay**	
Scheduled prenatal care visits and postpartum visits	$0	45% Coinsurance after Deductible
Laboratory	$25 per department visit	45% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$25 per department visit	45% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible	45% Coinsurance after Deductible
Hospital Services	**You pay**	
Ambulance Services (per transport)	10% Coinsurance after Deductible	
Emergency services	20% Coinsurance after Deductible	
Inpatient Hospital Services	20% Coinsurance after Deductible	45% Coinsurance after Deductible
Outpatient Services (other)	**You pay**	
Outpatient surgery visit	20% Coinsurance after Deductible	45% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible	45% Coinsurance after Deductible
Durable medical equipment	20% Coinsurance after Deductible	45% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per therapy per Year)	20% Coinsurance after Deductible	45% Coinsurance after Deductible
Skilled Nursing Facility Services	**You pay**	
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible	45% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	**You pay**	
Outpatient Services	$5 for the first 3 visits; then $25 per visit for additional visits in the same Year *	45% Coinsurance after Deductible
Inpatient hospital & residential Services	20% Coinsurance after Deductible	45% Coinsurance after Deductible
Alternative Care	**You pay**	
Acupuncture Services	Rider Available for Purchase	
Chiropractic Services		
Massage Therapy		
Naturopathic Medicine	$5 for the first 3 visits; then $25 for additional visits in the same Year *	45% 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.)	$25	45% 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.)	$25	45% 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.

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