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

Washington KP PLUS Everyday Care Plan $4000 **1/1/2025 - 12/31/2025**

	In-Network	Out-of-Network
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.		
Deductible Services that are subject to the Deductible are indicated below. After you meet your Deductible, you pay the Cost Share amount shown in this summary.		
Self-only Deductible per Year (for a Family of one Member)	$4,000	Not applicable
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$4,000	Not applicable
Family Deductible per Year (for an entire Family)	$8,000	Not applicable
Out-of-Pocket Maximum [1]		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$4,000	Not applicable
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$4,000	Not applicable
Family Out-of-Pocket Maximum per Year (for an entire Family)	$8,000	Not applicable

	In-Network	Out-of-Network [2] (Limited to 10 covered Services per Year, combined)
When you receive covered Services from Participating Providers, you pay the In-Network Cost Share shown below. When you receive covered Services from Non-Participating Providers, you pay the Out-of-Network Cost Share shown below.		
Office Visits	**You pay**	
Routine preventive physical exam	$0	$20
Telehealth (phone/video)	$0	Cost Share applicable to the Service when provided in person
Primary Care	$0	$20
Specialty Care	$0	$30
Urgent Care	$0	Not covered, except for Services received outside the Service Area [3]

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Tests (outpatient)	You pay	
Preventive Tests	$0	$20
Laboratory	$0	$20 per department visit
X-ray and imaging	$0	$20 per department visit
CT, MRI, PET scans	$500 per department visit	Not covered
Medications (outpatient)	**You pay**	
Prescription drugs (up to a 30-day supply)	$0 generic / $50 preferred brand / $125 non-preferred brand / $250 specialty	Out-of-Network Pharmacy [4] $20 generic / $70 preferred brand / $145 non-preferred brand / $270 specialty
Mail Order Prescription drugs (up to a 90-day supply)	$0 generic / $100 preferred brand / $250 non-preferred brand	Not covered
Administered medications, including injections (all outpatient settings)	$0 after Deductible	Not covered
Nurse treatment room visits to receive injections	$0	$20
Maternity Care	**You pay**	
Scheduled prenatal care visits and postpartum visit	$0	$20
Laboratory	$0	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$0	$20 per department visit
Inpatient Hospital Services	$0 after Deductible	Not covered
Hospital Services	**You pay**	
Ambulance Services (per transport)	$500	Covered In-Network [3]
Emergency services	$500 (Waived if admitted)	Covered In-Network [3]
Inpatient Hospital Services	$0 after Deductible	Not covered
Outpatient Services (other)	**You pay**	
Outpatient surgery visit	$0 after Deductible	Not covered
Chemotherapy/radiation therapy visit	$0 after Deductible	Not covered
Durable medical equipment	$0 after Deductible	Not covered
Physical, speech, and occupational therapies (20 visits per therapy per Year)	$0	$30
Skilled Nursing Facility Services	**You pay**	
Inpatient skilled nursing Services (up to 100 days per Year)	$0 after Deductible	Not covered
Mental Health and Substance Use Disorder Services	**You pay**	
Outpatient Services	$0	$20 per visit
Inpatient hospital & residential Services	$0 after Deductible	Not covered

Alternative Care (self-referred)	**You pay**	
Acupuncture Services (up to 12 visits per Year)	$0	$30
Chiropractic Services (up to 12 visits per Year)	$0	$30
Massage Therapy	Rider available for purchase	
Naturopathic Medicine	$0	$20

Hearing Instruments (Includes hearing aids and bone-anchored hearing devices)	**You pay**	
$3,000 allowance for each hearing instrument per ear every 36 months	$0, then any amount by which price exceeds allowance	Not covered

Vision Services	**You pay**	
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$0	$20
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	Rider Available for Purchase	Not covered
Routine eye exam (For members 19 years and older.)	$0	$20
Vision hardware and optical Services (For members 19 years and older.)	Rider Available for Purchase	Not covered

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

[2] 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.**

[3] The 10 covered Services limit does not apply.

[4] Your plan includes up to 5 out-of-network prescription refills per year. Each prescription fill can be for up to a 30-day supply. You may be asked to pay the full cost for out-of-network prescriptions and submit a claim for reimbursement. The 10 covered Services limit does not apply.

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 Customer Service. In the case of a conflict between this summary and the EOC, the EOC will prevail.