KAISER PERMANENTE®

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

Customer Service: 1-866-616-0047

Summary of Medical Benefits

KP WA Bronze Added Choice 7000 w/VX

2025 Contract

	KP Select Providers	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 Select Providers also count toward the Deductible for Services from PPO Providers, and vice versa. The amounts you pay for Services from NonParticipating Providers only count toward the Deductible for Services from Non-Participating Providers.			
Self-only Deductible per Year (for a Family of one Member)	$7,000	$8,500	$11,000
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$7,000	$8,500	$11,000
Family Deductible per Year (for an entire Family)	$14,000	$17,000	$22,000
Out-of-Pocket Maximum [2]			
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$9,200	$9,200	$15,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$9,200	$9,200	$15,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$18,400	$18,400	$30,000
Office Visits		**You pay**	
Routine preventive physical exam	$0	$0	50% Coinsurance after Deductible
Telehealth (phone/video)	$0	$0	50% Coinsurance after Deductible
Primary Care	$50	$60	50% Coinsurance after Deductible
Specialty Care	$70 after Deductible	$85 after Deductible	50% Coinsurance after Deductible
Urgent Care	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible

KAISER PERMANENTE®

	KP Select Providers	PPO Providers	Non-Participating Providers [1]
Tests (outpatient)		**You pay**	
Preventive Tests	$0	$0	50% Coinsurance after Deductible
Laboratory	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
CT, MRI, PET scans	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
Medications (outpatient)		**You pay**	
Prescription drugs (up to a 30-day supply)	$30 generic / $60 preferred brand / 50% Coinsurance after Deductible non-preferred brand / 50% Coinsurance after Deductible specialty	At MedImpact Pharmacy $40 generic / $80 preferred brand/50% Coinsurance non-preferred brand after Deductible / 50% Coinsurance after Deductible for specialty drugs	
Mail Order Prescription drugs (up to a 90day supply)	$60 generic/ $120 preferred brand/ 50% Coinsurance after Deductible non-preferred brand	MedImpact Mail-Order call CVS Caremark 1-800-237-2767	
Administered medications, including injections (all outpatient settings)	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10	$60	50% Coinsurance after Deductible
Maternity Care		**You pay**	
Scheduled prenatal care visits and postpartum visit	$0	$0	50% Coinsurance after Deductible
Laboratory	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Hospital Services	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospital Services		**You pay**	
Ambulance Services (per transport)		40% Coinsurance after Deductible	
Emergency services		40% Coinsurance after Deductible	
Inpatient Hospital Services	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Services (other)		**You pay**	
Outpatient surgery visit	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$70 after Deductible	$85 after Deductible	50% Coinsurance after Deductible
Durable medical equipment	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical, speech, and occupational therapies (25 visits per Year)	$70 after Deductible	$85 after Deductible	50% Coinsurance after Deductible

KAISER PERMANENTE®

	KP Select Providers	PPO Providers	Non-Participating Providers[1]
Skilled Nursing Facility Services		**You pay**	
Inpatient skilled nursing Services (up to 60 days per Year)	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services		**You pay**	
Outpatient Services	$50 per visit	$60 per visit	50% Coinsurance after Deductible
Inpatient hospital & residential Services	40% Coinsurance after Deductible	45% Coinsurance after Deductible	50% Coinsurance after Deductible
Alternative Care (self-referred)		**You pay**	
Acupuncture Services (up to 12 visits per Year)	$70 per visit after Deductible	$85 after Deductible per visit	50% Coinsurance after Deductible
Chiropractic Services (up to 10 visits per Year)	$70 per visit after Deductible	$85 per visit after Deductible	50% Coinsurance after Deductible
Massage Therapy	Not covered	Not covered	Not covered
Naturopathic Medicine	$50	$60	50% 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.)	$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 12-month supply contact lenses per year.		50% Coinsurance after Deductible
Routine eye exam (For members 19 years and older.)	$50	$60	50% Coinsurance
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)[3]	Out-of-network benefit (reimbursement is based on UCC)[3]
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)** [3]	**Out-of-network benefit (reimbursement is based on UCC)** [3]
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] 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.

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.

KAISER PERMANENTE®