

Summary of Medical Benefits

KP WA Silver Added Choice 4000

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) | \$4,000 | \$6,000 | \$7,000 |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | \$4,000 | \$6,000 | \$7,000 |
| Family Deductible per Year (for an entire Family) | \$8,000 | \$12,000 | \$14,000 |
| Out-of-Pocket Maximum ² | | | |
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | \$8,900 | \$8,900 | \$14,000 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | \$8,900 | \$8,900 | \$14,000 |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | \$17,800 | \$17,800 | \$28,000 |
| 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 | \$45 | \$60 | 50% Coinsurance after Deductible |
| Specialty Care | \$60 | \$70 | 50% Coinsurance after Deductible |
| Urgent Care | \$70 | \$90 | 50% Coinsurance after Deductible |

| | KP Select Providers | PPO Providers | Non-Participating Providers ¹ |
|--|--|---|--|
| Tests (outpatient) | | | |
| | You pay | | |
| Preventive Tests | \$0 | \$0 | 50% Coinsurance after Deductible |
| Laboratory | \$45 per department visit | 45% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | \$45 per department visit | 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 non-preferred brand / 50% coinsurance after Deductible specialty | At MedImpact Pharmacy \$40 generic / \$70 preferred brand / 50% coinsurance non-preferred brand / 50% coinsurance after Deductible specialty | |
| Mail Order Prescription drugs (up to a 90day supply) | \$60 generic / \$120 preferred brand / 50% Coinsurance 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 | \$45 per department visit | 45% Coinsurance after Deductible | 50% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | \$45 per department visit | 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 | \$60 | \$70 | 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) | \$60 | \$70 | 50% Coinsurance after Deductible |

| | 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 | \$45 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) | \$60 per visit | \$70 per visit | 50% Coinsurance after Deductible |
| Chiropractic Services (up to 10 visits per Year) | \$60 per visit | \$70 per visit | 50% Coinsurance after Deductible |
| Massage Therapy | Not covered | Not covered | Not covered |
| Naturopathic Medicine | \$45 | \$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.) | Not covered | Not covered | Not covered |
| Vision hardware and optical Services (For members 19 years and older.) | Not covered | Not covered | Not covered |
| 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.