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

Summary of Medical Benefits

KP WA Silver HSA 3500

2025 Contract

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

Deductible	
Self-only Deductible per Year (for a Family of one Member)	$3,500
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$3,500
Family Deductible per Year (for an entire Family)	$7,000
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$6,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$6,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	$13,000
Office Visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0 after Deductible
Primary Care	25% Coinsurance after Deductible
Specialty Care	25% Coinsurance after Deductible
Urgent Care	25% Coinsurance after Deductible
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	25% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	25% Coinsurance after Deductible
CT, MRI, PET scans	25% Coinsurance after Deductible
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30-day supply)	After Deductible: $20 generic / $40 preferred brand / 30% Coinsurance non-preferred brand / 50% Coinsurance specialty
Mail Order Prescription drugs (up to a 90-day supply)	After Deductible: $40 generic / $80 preferred brand / 30% Coinsurance non-preferred brand
Administered medications, including injections (all outpatient settings)	25% Coinsurance after Deductible
Nurse treatment room visits to receive injections	25% Coinsurance after Deductible
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	$0
Laboratory	25% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	25% Coinsurance after Deductible
Inpatient Hospital Services	25% Coinsurance after Deductible

Hospital Services	**You pay**
Ambulance Services (per transport)	25% Coinsurance after Deductible
Emergency services	25% Coinsurance after Deductible
Inpatient Hospital Services	25% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	25% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	25% Coinsurance after Deductible
Durable medical equipment	25% Coinsurance after Deductible
Physical, speech, and occupational therapies (25 visits per Year)	25% Coinsurance after Deductible
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 60 days per Year)	25% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	**You pay**
Outpatient Services	25% Coinsurance after Deductible
Inpatient hospital & residential Services	25% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	25% Coinsurance after Deductible
Chiropractic Services (up to 10 visits per Year)	25% Coinsurance after Deductible
Massage Therapy	Not covered
Naturopathic Medicine	25% 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
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	No charge for eyeglass lenses, frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older.)	Not covered
Vision hardware and optical Services (For members 19 years and older.)	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)** [2]	**Out-of-network benefit (reimbursement is based on UCC)** [2]
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 after Deductible	50% Coinsurance after Deductible
Simple extractions	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Restorations (composite / acrylic and steel)	50% Coinsurance after Deductible	50% Coinsurance after Deductible

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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)** [2]	**Out-of-network benefit (reimbursement is based on UCC)** [2]
Oral Surgery Services	**You pay**	
Major oral surgery	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Surgical tooth extractions	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Periodontics	**You pay**	
Scaling and root planing	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Treatment of gum disease	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Endodontics	**You pay**	
Root canal and related therapy	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Major Restoration Services	**You pay**	
Bridges abutments	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Noble metal gold or porcelain crowns	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Inlays & Pontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Removable Prosthetic Services	**You pay**	
Full upper and lower dentures	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Partial dentures	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Rebases	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Relines	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Emergency Dental Care or Urgent Dental Care	The Cost Share that normally applies for non-emergency dental care Services	
Other Dental Services	**You pay**	
Nightguards (limit one every five years)	35% Coinsurance after Deductible	35% Coinsurance after Deductible
Nitrous oxide		
Adults and children age 13 years and older	$25 after Deductible	$25 after Deductible
Children age 12 years and younger	$25 after Deductible	$25 after Deductible
Orthodontics (medically necessary, diagnosis of cleft palate/lip)	50% Coinsurance after Deductible	50% Coinsurance after Deductible

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

[2] "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**.

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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.**

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000

All other areas: 1-800-813-2000. 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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