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 Oregon Standard Gold Plan

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)	$1,500
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$1,500
Family Deductible per Year (for an entire Family)	$3,000
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$7,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$7,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$14,000
Office visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0 *
Primary Care	$5 for first 3 visits; then $20 for additional visits in the same Year *
Specialty Care	$40
Urgent Care	$60
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	20% Coinsurance after Deductible
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30-day supply)	$10 generic / $30 preferred brand / 50% Coinsurance non-preferred brand / 50% Coinsurance (up to $500 maximum) specialty
Mail Order Prescription drugs (up to a 90-day supply)	$20 generic / $60 preferred brand / 50% Coinsurance non-preferred brand
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	20% Coinsurance after Deductible
Maternity Care	**You pay**
Scheduled prenatal care visits and postpartum visits	20% Coinsurance after Deductible
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible

Hospital Services	You pay
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency services	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	**You pay**
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (30 visits combined per Year)	$20
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 60 days per Year)	20% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	**You pay**
Outpatient Services	$5 for first 3 visits; then $20 per visit for additional visits in the same Year *
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$20 per visit
Chiropractic Services (up to 20 visits per Year)	$20 per visit
Massage Therapy	Not covered
Naturopathic Medicine	$5 for first 3 visits; then $20 for additional visits in the same Year *
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 one pair standard frames and lenses or 6-month supply contact lenses per year.
Routine eye exam (For members 19 years and older.)	Not covered
Vision hardware and optical Services (For members 19 years and older.)	Not covered

[1] 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.

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**.

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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