

Summary of Medical Benefits

KP OR Gold Added Choice OOA 1000 w/VX

2026 Contract

| 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 non-participating providers only count toward the deductible for services from non-participating providers.

| | | | |
|---------------------------------------------------------------------------------------------------|--------|--------|---------|
| Self-only deductible per year (for a family of one member) | \$1000 | \$1000 | \$6000 |
| Individual family member deductible per year (for each member in a family of two or more members) | \$1000 | \$1000 | \$6000 |
| Family deductible per year (for an entire family) | \$2000 | \$2000 | \$12000 |

Out-of-pocket maximum²

| | | | |
|--------------------------------------------------------------------------------------------------------------|---------|---------|---------|
| Self-only out-of-pocket maximum per year (for a family of one member) | \$7500 | \$7500 | \$11000 |
| Individual family member out-of-pocket maximum per year (for each member in a family of two or more members) | \$7500 | \$7500 | \$11000 |
| Family out-of-pocket maximum per year (for an entire family) | \$15000 | \$15000 | \$22000 |

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 | \$5 for first 3 visits, then \$35 for additional visits in the same year * | \$5 for the first 3 visits, then \$35 for additional visits in the same year * | 50% coinsurance after deductible |
| Specialty care | \$55 | \$55 | 50% coinsurance after deductible |
| Urgent care | \$75 | \$75 | 50% coinsurance after deductible |

| | Select providers | PPO providers | Non-participating providers ¹ | | |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--|--|
| Tests (outpatient) | | You pay | | | |
| Preventive tests | \$0 | \$0 | 50% coinsurance after deductible | | |
| Laboratory | \$35 | \$35 | 50% coinsurance after deductible | | |
| X-ray, imaging, and special diagnostic procedures | \$35 | \$35 | 50% coinsurance after deductible | | |
| CT, MRI, PET scans | \$300 | \$300 | 50% coinsurance after deductible | | |
| Medications (outpatient) | | You pay | | | |
| Prescription drugs (up to a 30-day supply) | \$15 generic / \$30 preferred brand / \$60 non-preferred brand / 50% coinsurance specialty | At MedImpact Pharmacy \$15 generic / \$30 preferred brand / \$60 non-preferred brand / 50% coinsurance specialty | | | |
| Mail order prescription drugs (up to a 90-day supply) | \$30 generic / \$60 preferred brand / \$180 non-preferred brand | MedImpact Mail-Order call CVS Caremark 1-800-237-2767 | | | |
| Administered medications, including injections (all outpatient settings) | 35% coinsurance after deductible | 35% coinsurance after deductible | 50% coinsurance after deductible | | |
| Nurse treatment room visits to receive injections | \$10 | \$10 | 50% coinsurance after deductible | | |
| Maternity care | | You pay | | | |
| Scheduled prenatal care visits and postpartum visits | \$0 | \$0 | 50% coinsurance after deductible | | |
| Laboratory | \$35 | \$35 | 50% coinsurance after deductible | | |
| X-ray, imaging, and special diagnostic procedures | \$35 | \$35 | 50% coinsurance after deductible | | |
| Inpatient hospital services | 35% coinsurance after deductible | 35% coinsurance after deductible | 50% coinsurance after deductible | | |
| Hospital services | | You pay | | | |
| Ambulance services (per transport) | 35% coinsurance after deductible | | | | |
| Emergency services | 35% coinsurance after deductible | | | | |
| Inpatient hospital services | 35% coinsurance after deductible | 35% coinsurance after deductible | 50% coinsurance after deductible | | |

| | Select providers | PPO providers | Non-participating providers ¹ |
|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------|
| Outpatient services (other) | | You pay | |
| Outpatient surgery visit | 35% coinsurance after deductible | 35% coinsurance after deductible | 50% coinsurance after deductible |
| Chemotherapy/radiation therapy visit | \$55 | \$55 | 50% coinsurance after deductible |
| Durable medical equipment | 35% coinsurance after deductible | 35% coinsurance after deductible | 50% coinsurance after deductible |
| Physical, speech, and occupational therapies (30 visits combined per year) | \$55 | \$55 | 50% coinsurance after deductible |
| Skilled nursing facility services | | You pay | |
| Inpatient skilled nursing services (up to 60 days per year) | 35% coinsurance after deductible | 35% coinsurance after deductible | 50% coinsurance after deductible |
| Mental health and substance use disorder services | | You pay | |
| Outpatient services | \$5 for the first 3 visits, then \$35 for additional visits in the same year * | \$5 for the first 3 visits, then \$35 for additional visits in the same year * | 50% coinsurance after deductible |
| Inpatient hospital & residential services | 35% coinsurance after deductible | 35% coinsurance after deductible | 50% coinsurance after deductible |
| Alternative care | | You pay | |
| Acupuncture services (up to 12 visits per year) | \$25 per visit | \$25 per visit | 40% coinsurance |
| Chiropractic services (20 visits combined per year) | \$25 per visit | \$25 per visit | 40% coinsurance |
| Massage therapy | Not covered | Not covered | Not covered |
| Naturopathic medicine | \$5 for the first 3 visits, then \$35 for additional visits in the same year * | \$5 for the first 3 visits, then \$35 for additional visits in the same year * | 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 6-month supply contract lenses per year. | | 50% coinsurance after deductible |
| Routine eye exam (for members 19 years and older.) | \$35 | \$35 | 50% coinsurance |
| Vision hardware and optical services (for members 19 years and older.) | Balance after \$250 dollars for allowance per 24 months (calendar). | | |

| 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 | | You pay |
| Oral exam | \$0 | \$0 |
| X-rays | \$0 | \$0 |
| Teeth cleaning | \$0 | \$0 |
| Fluoride | \$0 | \$0 |
| Basic restoration services | | You pay |
| Routine fillings | 50% coinsurance | 50% coinsurance |
| Plastic and steel crowns | 50% coinsurance | 50% coinsurance |
| Simple extractions | 50% coinsurance | 50% coinsurance |
| Oral surgery services | | You pay |
| Surgical tooth extractions | 50% coinsurance | 50% coinsurance |
| Periodontics | | You pay |
| Treatment of gum disease | 50% coinsurance | 50% coinsurance |
| Scaling and root planing | 50% coinsurance | 50% coinsurance |
| Endodontics | | You pay |
| Root canal therapy | 50% coinsurance | 50% coinsurance |
| Major restoration services | | You pay |
| Gold or porcelain crowns | 50% coinsurance | 50% coinsurance |
| Bridges | 50% coinsurance | 50% coinsurance |
| Removable prosthetic services | | You pay |
| Full and partial dentures | 50% coinsurance | 50% coinsurance |
| Relines | 50% coinsurance | 50% coinsurance |
| Rebases | 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 | 35% coinsurance | 35% coinsurance |
| Nitrous oxide | \$25 | \$25 |
| Orthodontics (medically necessary, diagnosis of cleft palate/lip) | | 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.

* 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.

Questions? Call customer service at 1-866-616-0047 (M-F, 8 a.m.-6 p.m.) 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.

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: 711).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For Washington Members:

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-813-2000** (TTY: 711).

አማርኛ (Amharic) ትኩረት: አማርኛ የሚገኘውን ከሆነ ተግባራ የሆነ ለዚህ መረጃዎችን እና አገልግሎቶችን ማያዣድ የሚገኘውን እና የሚገኘውን እና አገልግሎቶችን በነፃ ይገልጻል:: በ 1-800-813-2000 ይደውሉ (TTY: 711)::

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電**1-800-813-2000** (TTY: 711)。

فارسی (Farsi) توجہ اگر بے فاہارسی صصحت مکنی د، همسیلات نیلی «، از جمل مکمکا و خدمات پیشنهادی نہ اس بے صورت ریگان دوس ترست انسان سبکی د (YAT) لفون تقی (711).

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-813-2000** (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie 1-800-813-2000 an (TTY: 711).

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。1-800-813-2000までお電話ください (TTY: 711)。

ខ្មែរ (Khmer) យកចិត្តទៅរាជការ: បើអ្នកនិយាយខ្មែរ សេវាដំឡើយភាសា អ្នកទាំងដំឡើយនឹងសេវាសម្របដោយគគិតគិតថ្មី មានចំពោះអ្នក ហើយ **1-800-813-2000** (TTY: 711).

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-813-2000**로 전화해 주세요(TTY: 711).

ລາວ (Laotian) ເອົາໄລໃສ໌: ຖ້າທ່ານວັ້ນພາກສາວ, ການບໍລິການຂ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຂ່ວຍເຫຼືອທີ່ເໝາະສົມ ລະນີໃຫ້ທ່ານໄດ້ລົບເສັລຄ້າ. ໃທ 1-800-813-2000 (TTY: 711).

Afaan Oromoo (Oromo) XIYYEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira.
1-800-813-2000 irratti bilbilaa (TTY: 711)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਤਾ ਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- 711).

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la 1-800-813-2000 (TTY: 711).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-813-2000** (TTY: 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al 1-800-813-2000 (TTY: 711).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: 711).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: 711).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-800-813-2000** (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: 711).