KAISER PERMANENTE®

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 OR Platinum KP Plus 0 w/VX

2026 Contract

	In-network	Out-of-network
Calendar year is the time period (year) in which dollar, day, and visit limits, deductibles and out-of-pocket maximums accumulate.		
Deductible		
Services that are subject to the deductible are indicated below. After you meet your deductible, you pay the cost share amount shown in this summary.		
Self-only deductible per year (for a family of one member)	None	Not applicable
Individual family member deductible per year (for each member in a family of two or more members)	None	Not applicable
Family deductible per year (for an entire family)	None	Not applicable
Out-of-pocket maximum [1]		
Self-only out-of-pocket maximum per year (for a family of one member)	$2800	Not applicable
Individual family member out-of-pocket maximum per year (for each member in a family of two or more members)	$2800	Not applicable
Family out-of-pocket maximum per year (for an entire family)	$5600	Not applicable

	In-network	Out-of-network [2] (limited to 10 covered services per year, combined)
When you receive covered services from participating providers, you pay the in-network cost share shown below. When you receive covered services from non-participating providers, you pay the out-of-network cost share shown below.		
Office visits	**You pay**	
Routine preventive physical exam	$0	$0
Telehealth (phone/video)	$0*	$0
Primary care	$5 for first 3 visits, then $20 for additional visits in the same year *	$40
Specialty care	$30	$50
Urgent care	$40	Not covered, except for services received outside the service area [3]

	In-network	Out-of-network [2] (limited to 10 covered services per year, combined)
Tests (outpatient)	**You pay**	
Preventive tests	$0	$0
Laboratory	$20	$40
X-ray, imaging, and special diagnostic procedures	$30	$50
CT, MRI, PET scans	$75	Not covered
Medications (outpatient)	**You pay**	
Prescription drugs (up to a 30-day supply)	$5 generic / $15 preferred brand / $50 non-preferred brand / 50% coinsurance specialty	$25 generic / $35 preferred brand / $70 non-preferred brand / 50% coinsurance specialty (limited to 5 prescription fills per year) [3]
Mail order prescription drugs (up to a 90-day supply)	$10 generic / $30 preferred brand / $150 non-preferred brand	Not covered
Administered medications, including injections (all outpatient settings)	20% coinsurance	Not covered
Nurse treatment room visits to receive injections	$10	$30
Maternity care	**You pay**	
Scheduled prenatal care visits and postpartum visit	$0	$0
Laboratory	$20	$40
X-ray, imaging, and special diagnostic procedures	$30	$50
Inpatient hospital services	$300 per day up to $1500 per admission	Not covered
Hospital services	**You pay**	
Ambulance services (per transport)	$150	Covered in-network [3]
Emergency services	$200 (waived if admitted)	Covered in-network [3]
Inpatient hospital services	$300 per day up to $1500 per admission	Not covered
Outpatient services (other)	**You pay**	
Outpatient surgery visit	$200	Not covered
Chemotherapy/radiation therapy visit	$30	Not covered
Durable medical equipment	20% coinsurance	Not covered
Physical, speech, and occupational (30 visits combined per year)	$30	$50
Skilled nursing facility services	**You pay**	
Inpatient skilled nursing services (up to 60 days per year)	$300 per day up to $1500 per admission	Not covered

	In-network	Out-of-network [2] (limited to 10 covered services per year, combined)
Mental health and substance use disorder services	**You pay**	
Outpatient services	$5 for the first 3 visits, then $20 for additional visits in the same year *	$40
Inpatient hospital & residential services	$300 per day up to $1500 per admission	Not covered
Alternative care (self-referred)	**You pay**	
Acupuncture services (up to 12 visits per year)	$25 per visit	$45 per visit
Chiropractic services (20 visits combined per year)	$25 per visit	$45 per visit
Massage therapy	Not covered	Not covered
Naturopathic medicine	$5 for first 3 visits; then $20 for additional visits in the same year *	$40
Vision services	**You pay**	
Routine eye exam (covered until the end of the month in which member turns 19 years of age.)	$0	Not covered
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.	Not covered
Routine eye exam (for members 19 years and older.)	$20	$40
Vision hardware and optical services (for members 19 years and older.)	Balance after $250 dollars for allowance per 24 months (calendar).	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)** [4]	**Out-of-network benefit (reimbursement is based on UCC)** [4]
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	50% coinsurance

1 Refer to your *Evidence of Coverage* (*EOC*) for benefits that may not apply to out-of-pocket maximum.

2 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**.

3 The 10 covered services limit does not apply.

4 "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 received in-network.

KAISER PERMANENTE®

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the *Evidence of Coverage* (*EOC*). Sample *EOC*s 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 Customer Service. In the case of a conflict between this summary and the *EOC*, the *EOC* will prevail.

KAISER PERMANENTE®

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**.

This notice is available at https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice

---

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 የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: **711**)።

العربية(Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-813-2000** (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) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با**1-800-813-2000** (TTY (تلفن متنی): **711**) تماس بگیرید.

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) យកចិត្តទុកដាក់៖ បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសម្រួលដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **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) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັ້ງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: 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 ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ 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**).