

# Summary of Medical Benefits

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

**Oregon**

**1/1/2026 - 12/31/2026**

**Marion County**

**Group Number: 1522-042**

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)                                        | \$500   |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | \$500   |
| Family Deductible per Year (for an entire Family)                                                 | \$1,500 |

## Out-of-Pocket Maximum <sup>1</sup>

|                                                                                                              |         |
|--------------------------------------------------------------------------------------------------------------|---------|
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)                                        | \$3,000 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | \$3,000 |
| Family Out-of-Pocket Maximum per Year (for an entire Family)                                                 | \$9,000 |

## Office Visits

|                                  | You pay                                                                    |
|----------------------------------|----------------------------------------------------------------------------|
| Routine preventive physical exam | \$0                                                                        |
| Telehealth (phone/video)         | \$0 *                                                                      |
| Primary Care                     | \$5 for first 3 visits; then \$15 for additional visits in the same Year * |
| Specialty Care                   | \$30                                                                       |
| Urgent Care                      | \$40                                                                       |

## Tests (outpatient)

|                                                   | You pay                    |
|---------------------------------------------------|----------------------------|
| Preventive Tests                                  | \$0                        |
| Laboratory                                        | \$15 per department visit  |
| X-ray, imaging, and special diagnostic procedures | \$15 per department visit  |
| CT, MRI, PET scans                                | \$100 per department visit |

## Medications (outpatient)

|                                                                          | You pay                                                                                     |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Prescription drugs (up to a 30 day supply)                               | \$10 generic / \$30 preferred brand / 50% Coinsurance (up to \$100 max) non-preferred brand |
| Mail Order Prescription drugs (up to a 90 day supply)                    | \$20 generic / \$60 preferred brand / 50% Coinsurance (up to \$200 max) non-preferred brand |
| Administered medications, including injections (all outpatient settings) | \$0                                                                                         |
| Nurse treatment room visits to receive injections                        | \$10                                                                                        |

## Maternity Care

|                                                      | You pay                                 |
|------------------------------------------------------|-----------------------------------------|
| Scheduled prenatal care visits and postpartum visits | \$0                                     |
| Laboratory                                           | \$15 per department visit               |
| X-ray, imaging, and special diagnostic procedures    | \$15 per department visit               |
| Inpatient Hospital Services                          | \$100 per day up to \$500 per admission |

## Hospital Services

|  | You pay |
|--|---------|
|--|---------|

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|                                                                                                                  |                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Ambulance Services (per transport)                                                                               | 20% Coinsurance after Deductible                                                                                                                                                             |
| Emergency services                                                                                               | \$200 after Deductible (Waived if admitted)                                                                                                                                                  |
| Inpatient Hospital Services                                                                                      | \$100 per day up to \$500 per admission                                                                                                                                                      |
| <b>Outpatient Services (other)</b>                                                                               | <b>You pay</b>                                                                                                                                                                               |
| Outpatient surgery visit                                                                                         | \$20                                                                                                                                                                                         |
| Chemotherapy/radiation therapy visit                                                                             | \$30                                                                                                                                                                                         |
| Durable medical equipment                                                                                        | 20% Coinsurance after Deductible                                                                                                                                                             |
| Physical, speech, and occupational therapies (up to 20 visits per therapy per Year)                              | \$30                                                                                                                                                                                         |
| <b>Skilled Nursing Facility Services</b>                                                                         | <b>You pay</b>                                                                                                                                                                               |
| Inpatient skilled nursing Services (up to 100 days per Year)                                                     | \$0                                                                                                                                                                                          |
| <b>Mental Health and Substance Use Disorder Services</b>                                                         | <b>You pay</b>                                                                                                                                                                               |
| Outpatient Services                                                                                              | \$5 for first 3 visits; then \$15 per visit for additional visits in the same Year *                                                                                                         |
| Inpatient hospital & residential Services                                                                        | \$100 per day up to \$500 per admission                                                                                                                                                      |
| <b>Alternative Care (self-referred)</b>                                                                          | <b>You pay</b>                                                                                                                                                                               |
| Acupuncture Services (up to 12 visits per Year)                                                                  | \$40 per visit                                                                                                                                                                               |
| Chiropractic Services (up to 20 visits per Year)                                                                 | \$40 per visit                                                                                                                                                                               |
| Massage Therapy (up to 12 visits per Year)                                                                       | \$25 per visit                                                                                                                                                                               |
| Naturopathic Medicine                                                                                            | \$5 for first 3 visits; then \$15 for additional visits in the same Year *                                                                                                                   |
| <b>Vision Services</b>                                                                                           | <b>You pay</b>                                                                                                                                                                               |
| 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 12-month supply contact lenses per year.                                                                                                |
| Routine eye exam (For members 19 years and older.)                                                               | \$20                                                                                                                                                                                         |
| Vision hardware and optical Services (For members 19 years and older.)                                           | Allowance of up to \$200 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once every Year. |

<sup>1</sup> 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, behavioral 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](https://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>**.

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**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

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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.

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-800-813-2000 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-813-2000 (TTY: 711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                       | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$500 Individual / \$1,500 Family                                                                                                             | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                          |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.                                                      | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                     |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                           | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$3,000 Individual / \$9,000 Family                                                                                                           | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                           |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.           | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-813-2000 (TTY: 711) for a list of <a href="#">Participating Providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your plan pays <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Important Questions                                                          | Answers                                                              | Why this Matters:                                                                                                                                                                                                    |
|------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes, but you may self-refer to certain <a href="#">specialists</a> . | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                   | Services You May Need                                    | What You Will Pay Participating Provider (You will pay the least)                                                                  | What You Will Pay Non-Participating Provider (You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                       |
|------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness         | \$15 / visit, <a href="#">deductible</a> does not apply                                                                            | Not covered                                                          | \$5 / visit, <a href="#">deductible</a> does not apply for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.                         |
|                                                                        | <a href="#">Specialist</a> visit                         | \$30 / visit, <a href="#">deductible</a> does not apply                                                                            | Not covered                                                          | None                                                                                                                                                                                                                        |
|                                                                        | <a href="#">Preventive care/ screening/ immunization</a> | No charge, <a href="#">deductible</a> does not apply                                                                               | Not covered                                                          | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)      | Xray: \$15 / visit, <a href="#">deductible</a> does not apply. Lab tests: \$15 / visit, <a href="#">deductible</a> does not apply. | Not covered                                                          | None                                                                                                                                                                                                                        |
|                                                                        | Imaging (CT/PET scans, MRI's)                            | \$100 / visit, <a href="#">deductible</a> does not apply                                                                           | Not covered                                                          | Some services may require prior authorization.                                                                                                                                                                              |

| Common Medical Event                                                                                                                                                                                            | Services You May Need                            | What You Will Pay Participating Provider (You will pay the least)                                                                                                                           | What You Will Pay Non-Participating Provider (You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> | Generic drugs                                    | \$10 (retail) & \$20 (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.                                                                               | Not covered                                                          | Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.                                          |
|                                                                                                                                                                                                                 | Preferred brand drugs                            | \$30 (retail) & \$60 (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.                                                                               | Not covered                                                          | Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.                                          |
|                                                                                                                                                                                                                 | Non-preferred drugs                              | 50% <a href="#">coinsurance</a> up to \$100 (retail) & 50% <a href="#">coinsurance</a> up to \$200 (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply. | Not covered                                                          | Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines, when approved through exception process. |
|                                                                                                                                                                                                                 | <a href="#">Specialty drugs</a>                  | 50% <a href="#">coinsurance</a> up to \$100 (retail) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.                                                            | Not covered                                                          | Up to a 30-day supply (retail). Subject to <a href="#">formulary</a> guidelines, when approved through exception process.                                      |
| <b>If you have outpatient surgery</b>                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center)   | \$20 / visit, <a href="#">deductible</a> does not apply                                                                                                                                     | Not covered                                                          | Prior authorization required.                                                                                                                                  |
|                                                                                                                                                                                                                 | Physician/surgeon fees                           | No charge                                                                                                                                                                                   | Not covered                                                          | Physician/surgeon fees are included in the Facility fee.                                                                                                       |
| <b>If you need immediate medical attention</b>                                                                                                                                                                  | <a href="#">Emergency room care</a>              | \$200 / visit                                                                                                                                                                               | \$200 / visit                                                        | <a href="#">Copayment</a> waived if admitted directly to the hospital as an inpatient.                                                                         |
|                                                                                                                                                                                                                 | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                                                                                                                                                             | 20% <a href="#">coinsurance</a>                                      | None                                                                                                                                                           |
|                                                                                                                                                                                                                 | <a href="#">Urgent care</a>                      | \$40 / visit, <a href="#">deductible</a> does not apply                                                                                                                                     | Not covered                                                          | <a href="#">Non-Participating Providers</a> covered when temporarily outside the service area: \$40 / visit, <a href="#">deductible</a> does not apply.        |
| <b>If you have a hospital stay</b>                                                                                                                                                                              | Facility fee (e.g., hospital room)               | \$100 / day up to \$500 / admission, <a href="#">deductible</a> does not apply.                                                                                                             | Not covered                                                          | Prior authorization required.                                                                                                                                  |
|                                                                                                                                                                                                                 | Physician/surgeon fee                            | No charge                                                                                                                                                                                   | Not covered                                                          | Physician/surgeon fees are included in the Facility fee.                                                                                                       |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay Participating Provider (You will pay the least)                                                                                              | What You Will Pay Non-Participating Provider (You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                                    |
|----------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$15 / visit, <a href="#">deductible</a> does not apply                                                                                                        | Not covered                                                          | \$5 / visit, <a href="#">deductible</a> does not apply for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.                                      |
|                                                                                  | Inpatient services                        | \$100 / day up to \$500 / admission, <a href="#">deductible</a> does not apply.                                                                                | Not covered                                                          | Prior authorization required.                                                                                                                                                                                                            |
| <b>If you are pregnant</b>                                                       | Office visits                             | No charge, <a href="#">deductible</a> does not apply                                                                                                           | Not covered                                                          | Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                                  | Childbirth/delivery professional services | No charge                                                                                                                                                      | Not covered                                                          | Professional services are included in the facility fee.                                                                                                                                                                                  |
|                                                                                  | Childbirth/delivery facility services     | \$100 / day up to \$500 / admission, <a href="#">deductible</a> does not apply.                                                                                | Not covered                                                          | None                                                                                                                                                                                                                                     |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | No charge                                                                                                                                                      | Not covered                                                          | 130 visit limit / year. Prior authorization required.                                                                                                                                                                                    |
|                                                                                  | <a href="#">Rehabilitation services</a>   | Outpatient: \$30 / visit, <a href="#">deductible</a> does not apply Inpatient: \$100 / day up to \$500 / admission, <a href="#">deductible</a> does not apply. | Not covered                                                          | Outpatient: 20 visit limit / year. Prior authorization required. Inpatient: Prior authorization required.                                                                                                                                |
|                                                                                  | <a href="#">Habilitation services</a>     | \$30 / visit, <a href="#">deductible</a> does not apply                                                                                                        | Not covered                                                          | 20 visit limit / year. Prior authorization required.                                                                                                                                                                                     |
|                                                                                  | <a href="#">Skilled nursing care</a>      | No charge, <a href="#">deductible</a> does not apply                                                                                                           | Not covered                                                          | 100 day limit / year. Prior authorization required.                                                                                                                                                                                      |
|                                                                                  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                                                                                                                                | Not covered                                                          | Subject to <a href="#">formulary</a> guidelines. Prior authorization required.                                                                                                                                                           |
|                                                                                  | <a href="#">Hospice service</a>           | No charge, <a href="#">deductible</a> does not apply                                                                                                           | Not covered                                                          | Prior authorization required.                                                                                                                                                                                                            |

| Common Medical Event                          | Services You May Need      | What You Will Pay Participating Provider (You will pay the least)        | What You Will Pay Non-Participating Provider (You will pay the most) | Limitations, Exceptions & Other Important Information                          |
|-----------------------------------------------|----------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <b>If your child needs dental or eye care</b> | Children's eye exam        | No charge for refractive exam, <a href="#">deductible</a> does not apply | Not covered                                                          | None                                                                           |
|                                               | Children's glasses         | No charge, <a href="#">deductible</a> does not apply                     | Not covered                                                          | Limited to one pair of select frames and lenses or contact lenses / 12 months. |
|                                               | Children's dental check-up | Not covered                                                              | Not covered                                                          | None                                                                           |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                             |                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> <li>• Long-term care</li> </ul>                                                         | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>                      | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>         |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                                                             |                                                                                                               |
| <ul style="list-style-type: none"> <li>• Acupuncture (12 visit limit / year)</li> <li>• Bariatric surgery</li> </ul>                                                                              | <ul style="list-style-type: none"> <li>• Chiropractic care (20 visit limit/year)</li> <li>• Hearing aids (Under age 26: 1 aid / ear / 36 months)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul> |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

### Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

|                                                                                              |                                                                                                           |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Kaiser Permanente Member Services                                                            | 1-800-813-2000 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>     |
| Department of Labor's Employee Benefits Security Administration                              | 1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                         |
| Oregon Department of Insurance                                                               | 1-888-877-4894 or <a href="https://dfr.oregon.gov/">https://dfr.oregon.gov/</a>                           |
| Washington Department of Insurance                                                           | 1-800-562-6900 or <a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a>                          |

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-813-2000 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-813-2000 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-813-2000 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-813-2000 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-813-2000 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-813-2000 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-800-813-2000 (TTY: 711)

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$30  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$100 |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$15  |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$0             |
| <a href="#">Copayments</a>             | \$200           |
| <a href="#">Coinsurance</a>            | \$0             |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$260</b>    |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$30  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$100 |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$15  |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$600          |
| <a href="#">Coinsurance</a>            | \$10           |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Joe would pay is</b>      | <b>\$610</b>   |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$30  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$100 |
| ■ Other (x-ray) <a href="#">copayment</a>                       | \$15  |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$500          |
| <a href="#">Copayments</a>             | \$400          |
| <a href="#">Coinsurance</a>            | \$100          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$1,000</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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## 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
- Provide 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](http://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/online services/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** تماس بگیرید (TTY: تلفن متنی: **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 Sprachassistentz 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 រួមទាំងជំនួយនិងសេវាសមស្រប ដោយឥតគិតថ្លៃ 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 ລວມທັງອຸປະກອນ 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 ਮੁਫਤ 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**).