KAISER PERMANENTE®

Group: MULTNOMAH BAR ASSOCIATION #1568
Region: Northwest
Contract Period: 01/01/2027 to 12/31/2027
Summary of Benefits

DUAL CHOICE PPO HDHP 5000/20%/8000 EMB

Accumulation Details

The accumulation period is calendar year, and the accumulation type is Embedded.

Deductible(s) and Out-of-Pocket Maximum(s) Details

Cost Share amounts that count toward the Deductible are shown below. The In-Network Deductible and the Out-of-Network Deductible do not cross accumulate. This means that the amounts you pay for covered services received from In-Network Providers only count toward the In-Network Deductible, and the amounts you pay for covered services received from Out-of-Network Providers only count toward the Out-of-Network Deductible.

For services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Deductible(s)	**In-Network Providers**	**Out-of-Network Providers**[1]
Self-only Deductible per year (for a Family of one Member)	$5000	$7000
Individual Family Member Deductible per year (for each Member in a Family of two or more Members)	$5000	$7000
Family Deductible per year (for an entire Family)	$10000	$14000

Out-of-Pocket Maximum(s)[2]	**In-Network Providers**	**Out-of-Network Providers**
Self-only Out-of-Pocket Maximum per year (for a Family of one Member)	$8000	$17000
Individual Family Member Out-of-Pocket Maximum per year (for each Member in a Family of two or more Members)	$8000	$17000
Family Out-of-Pocket Maximum per year (for an entire Family)	$16000	$34000

Professional Services[3]	**In-Network Providers**	**Out-of-Network Providers**
Primary care office visit[4]	$5 After Deductible for first 3 visits, then 30% After Deductible for additional visits in the same year Enhanced Benefit: $5 After Deductible for first 3 visits, then 20% After Deductible for additional visits in the same year	40% Coinsurance After Deductible
Specialty care office visit	30% Coinsurance After Deductible Enhanced Benefit: 20% Coinsurance After Deductible	40% Coinsurance After Deductible
Telehealth[4]	0% After Deductible for first 3 visits, then 0% After Deductible for additional visits in the same year	40% Coinsurance After Deductible
Routine physical maintenance exams, including well-woman exams	No Charge	40% Coinsurance After Deductible
Well-child preventive exams (through age 23 months)	No Charge	40% Coinsurance After Deductible

Professional Services[3]	In-Network Providers	Out-of-Network Providers
Physical, occupational, and speech therapy	30% Coinsurance After Deductible (20 visits per therapy per year across provider networks) Enhanced Benefit: 20% Coinsurance After Deductible (20 visits per therapy per year across provider networks)	40% Coinsurance After Deductible (20 visits per therapy per year across provider networks)

Outpatient Services	In-Network Providers	Out-of-Network Providers
Outpatient surgery visits and certain other outpatient procedures	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Diagnostic X-rays	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Laboratory services	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Preventive X-rays, screenings, and laboratory tests	No Charge	40% Coinsurance After Deductible
Advanced imaging (CT / MRI / PET)	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Chemotherapy/radiation therapy visit	30% Coinsurance After Deductible Enhanced Benefit: 20% Coinsurance After Deductible	40% Coinsurance After Deductible

Medication Coverage	In-Network Providers	Out-of-Network Providers
Retail Pharmacy (up to 30-day supply)	Kaiser Permanente Pharmacy: Generic: $15 Aft Ded Brand: $30 Aft Ded Non Preferred: $50 Aft Ded Specialty: $250 Aft Ded MedImpact Pharmacy: Generic: $25 Aft Ded Brand: $50 Aft Ded Non Preferred: $80 Aft Ded Specialty: 30% Aft Ded	Not Covered
Mail order prescriptions (up to 90-day supply)	Kaiser Permanente Pharmacy: Two copayments at retail cost share MedImpact Pharmacy/ CVS Caremark: Three copayments at retail cost share.	Not Covered
Administered medications, including injections (all outpatient settings)	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Allergy injections	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Immunizations	No Charge	40% Coinsurance After Deductible

Maternity Care	In-Network Providers	Out-of-Network Providers
Scheduled prenatal care exams and postpartum visit	No Charge	40% Coinsurance After Deductible
Laboratory	20% Coinsurance After Deductible	40% Coinsurance After Deductible
X-Ray, imaging, and special diagnostic procedures	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Labor and Delivery Hospital Services	20% Coinsurance After Deductible	40% Coinsurance After Deductible

Hospitalization and Emergency Services	In-Network Providers	Out-of-Network Providers
Urgent care	30% Coinsurance After Deductible Enhanced Benefit: 20% Coinsurance After Deductible	40% Coinsurance After Deductible
Hospital room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance After Deductible	40% Coinsurance After Deductible

Hospitalization and Emergency Services	In-Network Providers	Out-of-Network Providers
Ambulance services (emergency transport)	20% Coinsurance After Deductible	Covered at the In-Network Providers cost share
Emergency department visits	20% Coinsurance After Deductible	Covered at the In-Network Providers cost share

Durable Medical Equipment (DME)	In-Network Providers	Out-of-Network Providers
Durable medical equipment	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Prosthetic and orthotic devices	20% Coinsurance After Deductible	40% Coinsurance After Deductible

Mental Health Services	In-Network Providers	Out-of-Network Providers
Inpatient psychiatric care	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Outpatient individual therapy visits[4]	$5 After Deductible for first 3 visits, then 30% After Deductible for additional visits in the same year Enhanced Benefit: $5 After Deductible for first 3 visits, then 20% After Deductible for additional visits in the same year	40% Coinsurance After Deductible

Substance Use Disorder Treatment	In-Network Providers	Out-of-Network Providers
Inpatient detoxification	20% Coinsurance After Deductible	40% Coinsurance After Deductible
Outpatient individual therapy visits[4]	$5 After Deductible for first 3 visits, then 30% After Deductible for additional visits in the same year Enhanced Benefit: $5 After Deductible for first 3 visits, then 20% After Deductible for additional visits in the same year	40% Coinsurance After Deductible

Home Health Services	In-Network Providers	Out-of-Network Providers
Home health care	20% Coinsurance After Deductible (up to 130 visits per year across provider networks)	40% Coinsurance After Deductible (up to 130 visits per year across provider networks)

Alternative Care	In-Network Providers	Out-of-Network Providers
Benefit maximum	Not Applicable	Not Applicable
Acupuncture care	$25 after deductible up to 12 visits per calendar year across provider networks	40% after deductible up to 12 visits per calendar year across provider networks
Chiropractic care	$25 after deductible up to 20 visits per calendar year across provider networks	40% Coinsurance after deductible up to 20 visits per calendar year across provider networks
Massage therapy	$25 after deductible up to 12 visits per calendar year across provider networks	40% coinsurance after deductible up to 12 visits per calendar year across provider networks
Naturopathic medicine[4]	$5 After Deductible for first 3 visits, then 20% After Deductible for additional visits in the same year	40% Coinsurance After Deductible

Other Professional Services	In-Network Providers	Out-of-Network Providers
Skilled nursing facility	20% Coinsurance After Deductible (up to 100 days per year across provider networks)	40% Coinsurance After Deductible (up to 100 days per year across provider networks)

Other Professional Services	In-Network Providers	Out-of-Network Providers
Hospice care	0% Coinsurance After Deductible	0% Coinsurance After Deductible
Fertility diagnosis	50% Coinsurance After Deductible	50% Coinsurance After Deductible
Fertility lab	50% Coinsurance After Deductible	50% Coinsurance After Deductible
Fertility treatment	Treatment Not Covered	Treatment Not Covered
Bariatric care	Covered	Not Covered
Adult hearing aid(s)	Not Covered	Not Covered
Pediatric hearing aid(s)	20% Coinsurance (1 per Ear / 36 months across provider networks)	40% Coinsurance After Deductible (1 per Ear / 36 months across provider networks)

Vision Services	In-Network Providers	Out-of-Network Providers
Pediatric Vision exam	0% Coinsurance After Deductible	40% Coinsurance After Deductible
Adult Vision exam	30% Coinsurance After Deductible Enhanced Benefit: 20% Coinsurance After Deductible	40% Coinsurance After Deductible
Pediatric optical eyewear	One Pair / 1 calendar year across provider networks	50% Allowance / One Pair / 1 calendar year / After Deductible across provider networks
Adult optical eyewear	$150 Allowance / 2 calendar years across provider networks	$150 Allowance / 2 calendar years across provider networks

1. Out-of-Network Providers may bill you for any charges in excess of the Allowed Amount (balance billing).
2. Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.
3. You pay the lowest Cost Share when you receive certain covered Services from a designated group of In-Network Providers. This is called "Enhanced Benefits." Enhanced Benefits are shown in this summary. In-Network Providers who offer Enhanced Benefits are identified with an asterisk (*) in the provider directory. Visit **kp.org/choiceproducts/nw** for a searchable provider directory.
4. First 3 visits 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 from all contracted providers combined.

Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). Sample Evidence of Coverages are available upon request or you may go to http://www.kp.org/plandocuments

Questions? Call Customer Service: 1-866-616-0047 (M-F, 8 am-6 pm) or visit **kp.org.**
All areas: 1-800-813-2000. TTY: 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 Evidence of Coverage or call Customer Service. In the case of a conflict between this summary and the Evidence of Coverage, the Evidence of Coverage 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

KAISER PERMANENTE®

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 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 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**).

KAISER PERMANENTE®

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**).