# 2025
# Medical, dental and vision plan summaries and rates

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# 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 - Deductible Plan** **1/1/2025 - 12/31/2025**

**Metro** **Group Number: 1543-073**

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) | $150 |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | $150 |
| Family Deductible per Year (for an entire Family) | $450 |
| **Out-of-Pocket Maximum [1]** | |
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | $1,150 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | $1,150 |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | $3,450 |
| **Office Visits** | **You pay** |
| Routine preventive physical exam | $0 |
| Telehealth (phone/video) | $0 * |
| Primary Care | $5 for first 3 visits; then $10 for additional visits in the same Year * |
| Specialty Care | $20 |
| Urgent Care | $30 |
| **Tests (outpatient)** | **You pay** |
| Preventive Tests | $0 |
| Laboratory | $10 per department visit |
| X-ray, imaging, and special diagnostic procedures | $10 per department visit |
| CT, MRI, PET scans | $100 per department visit |
| **Medications (outpatient)** | **You pay** |
| Prescription drugs (up to a 30 day supply) | $15 generic / $30 preferred brand |
| Mail Order Prescription drugs (up to a 90 day supply) | $30 generic / $60 preferred brand |
| Administered medications, including injections (all outpatient settings) | 10% Coinsurance after Deductible |
| Nurse treatment room visits to receive injections | $10 |
| **Maternity Care** | **You pay** |
| Scheduled prenatal care visits and postpartum visits | $0 |
| Laboratory | $10 per department visit |
| X-ray, imaging, and special diagnostic procedures | $10 per department visit |
| Inpatient Hospital Services | 10% Coinsurance after Deductible |
| **Hospital Services** | **You pay** |
| Ambulance Services (per transport) | 10% Coinsurance after Deductible |
| Emergency services | 10% Coinsurance after Deductible |
| Inpatient Hospital Services | 10% Coinsurance after Deductible |
| **Outpatient Services (other)** | **You pay** |

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| | |
|---|---|
| Outpatient surgery visit | 10% Coinsurance after Deductible |
| Chemotherapy/radiation therapy visit | $20 after Deductible |
| Durable medical equipment | 10% Coinsurance after Deductible |
| Physical, speech, and occupational therapies (up to 20 visits per therapy per Year) | $20 |
| **Skilled Nursing Facility Services** | **You pay** |
| Inpatient skilled nursing Services (up to 100 days per Year) | 10% Coinsurance after Deductible |
| **Mental Health and Substance Use Disorder Services** | **You pay** |
| Outpatient Services | $5 for first 3 visits; then $10 per visit for additional visits in the same Year * |
| Inpatient hospital & residential Services | 10% Coinsurance after Deductible |
| **Alternative Care** (self-referred) | **You pay** |
| Acupuncture Services (up to 12 visits per Year) | $10 per visit |
| Chiropractic Services (up to 20 visits per Year) | $10 per visit |
| Massage Therapy (up to 12 visits per Year) | $25 per visit |
| Naturopathic Medicine | $5 for first 3 visits; then $10 for additional visits in the same Year * |
| **Vision Services** | **You pay** |
| Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.) | $10 |
| Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.) | Not covered |
| Routine eye exam (For members 19 years and older.) | $10 |
| Vision hardware and optical Services (For members 19 years and older.) | Not covered |

[1] Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

* First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, 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**.

Non-participating providers may bill you for any charges in excess of the Allowed Amount (balance billing), except where balance billing is prohibited by law. You are protected from balance billing in connection with emergency services and certain services provided at a participating hospital or ambulatory surgical center. For additional information, visit **https://healthy.kaiserpermanente.org/oregon-washington/support/pay-bills/medical-bills/no-surprises-act.**

**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit **kp.org.** Portland area: 503-813-2000
All other areas: 1-800-813-2000. TTY, all areas: 711. Language Interpretation Services, all areas: 1-800-324-8010

This is not a contract. This condensed summary of benefits does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

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# Metro
## Regence Classic

***Effective January 1, 2025 through December 31, 2025***

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

| Cost Share Details | | In-Network | Out-of-Network |
|---|---|---|---|
| Annual Medical Deductible | The total deductible You pay per calendar year | $250 Individual<br>$750 Family | $750 Individual<br>$2,250 Family |
| Annual Prescription Deductible | The total deductible You pay per calendar year for prescription medications | Not applicable | |
| Annual Out-of-Pocket Maximum | The combined total for Your deductible(s), coinsurance and copays per calendar year. Ambulance, blood bank, emergency room services, and Prescription Medications apply towards the In-Network amount | $1,250 Individual<br>$3,750 Family | $3,500 Individual<br>$10,500 Family |
| Be aware that Your actual costs for Covered Services provided by an Out-of-Network provider may exceed the Out-of-Network Out-of-Pocket Maximum amount. In addition, Out-of-Network providers and Out-of-Network pharmacies can bill You for the difference between the amount charged and Our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum. | | | |
| **Medical Benefits** (***unless stated otherwise, a deductible applies***) | | **What You Pay** | |
| | | **In-Network** | **Out-of-Network** |
| Primary Care Visits (for Illness or Injury) | | First 3 Primary Care, Behavioral Health and Virtual Care visits combined, $5 copay per visit, deductible waived<br><br>After 3 visits, $20 copay per visit, deductible waived | 30% |
| Specialist Visits | | $30 copay per visit, deductible waived | 30% |
| Urgent Care Visits | | $20 copay/primary per visit, deductible waived<br><br>$30 copay/specialist per visit, deductible waived | 30% |
| Other Professional Services | | 10% | 30% |
| Preventive Care / Immunizations | Wellness Rewards available | Covered in full | 30% |
| Radiology and Laboratory - Outpatient | | 10% | 30% |
| Complex Imaging - Outpatient | | 10% | 30% |
| Acupuncture | 25 visits per calendar year | $20 copay per visit, deductible waived | 30% |
| Ambulance Services | Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment | 10% In-Network deductible applies | |
| Ambulatory Surgical Center | | 5% | 30% |
| Behavioral Health - Inpatient | | 10% | 30% |
| Behavioral Health - Outpatient | | First 3 Primary Care, Behavioral Health and Virtual Care visits combined, $5 copay per visit, deductible waived<br><br>After 3 visits, $20 copay per outpatient office / psychotherapy visit, deductible waived | 30% |
| Emergency Room | Facility and professional services | $200 copay per visit, then In-Network deductible and 10% coinsurance | |
| Hearing Aids, Cochlear Implants and Assistive Listening Devices | Limitations apply<br>Excludes: routine hearing examinations, television caption decoder or cords | 10%, deductible waived | 30%, deductible waived |
| Hospital Care | See Ambulatory Surgical Center for cost reduction option | 10% | 30% |
| Maternity Care | | 10% | 30% |

| Medical Benefits (*unless stated otherwise, a deductible applies*) | | What You Pay | |
|---|---|---|---|
| | | In-Network | Out-of-Network |
| Neurodevelopmental Therapy | 20 visits per calendar year | $20 copay per visit, deductible waived | 30% |
| Newborn Home Visits | Within 6 months of age, at least one visit during first 3 months, with up to 3 more available | Covered in full | Not covered |
| Rehabilitation Services - Inpatient | 30 days per calendar year | 10% | 30% |
| Rehabilitation Services - Outpatient | 20 visits per calendar year | $20 copay per visit, deductible waived | 30% |
| Skilled Nursing Facility | 100 days per calendar year | 10% | 30% |
| Spinal Manipulations | 25 visits per calendar year | $20 copay per visit, deductible waived | 30% |
| Virtual Care - Telehealth | Doctor visits via phone or video chat when not in a healthcare facility (includes Behavioral Health visits) | First 3 Primary Care, Behavioral Health and Virtual Care visits combined, $5 copay per visit, deductible waived<br><br>After 3 visits, $20 copay per visit, deductible waived<br>After 3 visits:<br>**Vendor: Doctor on Demand**<br>$10 copay per visit, deductible waived<br><br>**In-Network non-Vendor Provider:**<br>$20 copay per visit, deductible waived | 30% |

| Prescription Medication Benefits | | What You Pay |
|---|---|---|
| Tier 1 | 90-day supply for retail or home delivery | $15 retail prescription* / $30 home delivery prescription / $10 for each self-administrable Cancer Chemotherapy medication |
| Tier 2 | 90-day supply for retail or home delivery | $30 retail prescription* / $60 home delivery prescription / $50 for each self-administrable Cancer Chemotherapy medication |
| Tier 3 | 90-day supply for retail or home delivery | $45 retail prescription* /$90 home delivery prescription / $100 for each self-administrable Cancer Chemotherapy medication |
| Specialty Select | 30-day supply for retail | Refer to tiers 1, 2 and 3 above for specialty drugs |

**1 copay per 30-day supply*
***Insulin Cost Share Cap:*** *Retail or home delivery: $35 cap on Member cost share per 30-day supply; $105 cap on Member cost share up to 90-day supply. You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and / or coinsurance*
*More information about prescription drug coverage, including tier specific information, is available at https://regence.com/go/2025/OR/3tier*

| Value-Added Services | |
|---|---|
| Your Regence coverage includes access to the value-added services detailed here. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS.** For additional information regarding any of these value-added services, visit Our website or contact Customer Service. | |
| Joint, Spine, and Muscle Program | The Joint, Spine, and Muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles. |
| Kidney Health Management | If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD). |
| Mobile APP | Quick access to: ID card, chat with Customer Service, View Claims, Estimate Treatment Cost, Pharmacy pricing. |
| Nurse Advice | You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care 24 / 7. However, if You are experiencing a medical emergency, immediately call 911 instead. |
| Pregnancy Program | Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions; the Pregnancy Program can help. |
| Regence Advantages | Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. |
| Regence Empower | Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. Wellness Rewards available. |

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# 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 - High Deductible Health Plan (HSA-Qualified)** **1/1/2025 - 12/31/2025**

**Metro** **Group Number: 1543-055**

| | |
|---|---|
| Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate. | |
| **Deductible** (Aggregate Accumulation: If two or more family members are enrolled on the plan, the overall family deductible must be met. After the deductible is met, you pay the applicable copays/coinsurance for the rest of the year until the out-of-pocket maximum is met.) | |
| Self-only Deductible per Year (for a Family of one Member) | $1,650 |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | $3,300 |
| Family Deductible per Year (for an entire Family) | $3,300 |
| **Out-of-Pocket Maximum** [1] (Aggregate Accumulation: If two or more family members are enrolled on the plan, the overall family out-of-pocket maximum must be met. After the out-of-pocket maximum is met, no copays/coinsurance is required for the rest of the year.) | |
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | $3,500 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | $6,850 |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | $6,850 |
| **Office Visits** | **You pay** |
| Routine preventive physical exam | $0 |
| Telehealth (phone/video) | $0 after Deductible * |
| Primary Care | $5 after Deductible for first 3 visits; then 20% Coinsurance after Deductible for additional visits in the same Year * |
| Specialty Care | 20% Coinsurance after Deductible |
| Urgent Care | 20% Coinsurance after Deductible |
| **Tests (outpatient)** | **You pay** |
| Preventive Tests | $0 |
| Laboratory | 20% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | 20% Coinsurance after Deductible |
| CT, MRI, PET scans | 20% Coinsurance after Deductible |
| **Medications (outpatient)** | **You pay** |
| Prescription drugs (up to a 30 day supply) | After Deductible: $15 generic / $30 preferred brand |
| Mail Order Prescription drugs (up to a 90 day supply) | After Deductible: $30 generic / $60 preferred brand |
| Administered medications, including injections (all outpatient settings) | 20% Coinsurance after Deductible |
| Nurse treatment room visits to receive injections | $10 after Deductible |
| **Maternity Care** | **You pay** |
| Scheduled prenatal care visits and postpartum visits | $0 |
| Laboratory | 20% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | 20% Coinsurance after Deductible |

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| | |
|---|---|
| Inpatient Hospital Services | 20% Coinsurance after Deductible |
| **Hospital Services** | **You pay** |
| Ambulance Services (per transport) | 20% Coinsurance after Deductible |
| Emergency services | 20% Coinsurance after Deductible |
| Inpatient Hospital Services | 20% Coinsurance after Deductible |
| **Outpatient Services (other)** | **You pay** |
| Outpatient surgery visit | 20% Coinsurance after Deductible |
| Chemotherapy/radiation therapy visit | 20% Coinsurance after Deductible |
| Durable medical equipment | 20% Coinsurance after Deductible |
| Physical, speech, and occupational therapies (up to 20 visits per therapy per Year) | 20% Coinsurance after Deductible |
| **Skilled Nursing Facility Services** | **You pay** |
| Inpatient skilled nursing Services (up to 100 days per Year) | 20% Coinsurance after Deductible |
| **Mental Health and Substance Use Disorder Services** | **You pay** |
| Outpatient Services | $5 after Deductible for first 3 visits; then 20% Coinsurance after Deductible for additional visits in the same Year * |
| Inpatient hospital & residential Services | 20% Coinsurance after Deductible |
| **Alternative Care** (self-referred) | **You pay** |
| Acupuncture Services (up to 12 visits per Year) | $25 per visit after Deductible |
| Chiropractic Services (up to 20 visits per Year) | $25 per visit after Deductible |
| Massage Therapy (up to 12 visits per Year) | $25 per visit after Deductible |
| Naturopathic Medicine | $5 after Deductible for first 3 visits; then 20% Coinsurance after Deductible for additional visits in the same Year * |
| **Vision Services** | **You pay** |
| Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.) | 20% Coinsurance after Deductible |
| Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.) | Not covered |
| Routine eye exam (For members 19 years and older.) | 20% Coinsurance after Deductible |
| Vision hardware and optical Services (For members 19 years and older.) | Not covered |

[1] Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

* First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, 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**.

Non-participating providers may bill you for any charges in excess of the Allowed Amount (balance billing), except where balance billing is prohibited by law. You are protected from balance billing in connection with emergency services and certain services provided at a participating hospital or ambulatory surgical center. For additional information, visit **https://healthy.kaiserpermanente.org/oregon-washington/support/pay-bills/medical-bills/no-surprises-act**.

**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit **kp.org.** Portland area: 503-813-2000
All other areas: 1-800-813-2000. TTY, all areas: 711. Language Interpretation Services, all areas: 1-800-324-8010

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# Metro
## Regence HSA Healthplan 3.0

***Effective January 1, 2025 through December 31, 2025***

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

| Cost Share Details | | In-Network | Out-of-Network |
|---|---|---|---|
| Annual Medical Deductible | The total deductible You pay per calendar year | $1,650 Individual<br>$3,300 Family | $3,300 Individual<br>$6,600 Family |
| Annual Prescription Deductible | The total deductible You pay per calendar year for prescription medications | Shared with In-Network medical | |
| Annual Out-of-Pocket Maximum | The combined total for Your deductible(s), coinsurance and copays per calendar year. Ambulance, blood bank, emergency room services, and Prescription Medications apply towards the In-Network amount. | $3,300 Individual<br>$6,300 Family | $9,900 Individual<br>$18,900 Family |

Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If You have other Family Members on the plan, the overall family deductible must be met before the plan begins to pay.

The In-Network Out-of-Pocket Maximum for any Member on Family Coverage is not to exceed $6,300, including the In-Network Deductible. If a Member reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, including the In-Network Deductible, benefits will be paid at 100% of the Allowed Amount for that Member.

Be aware that your actual costs for Covered Services provided by an Out-of-Network provider may exceed the Out-of-Network Out-of-Pocket Maximum amount. In addition, Out-of-Network providers and Out-of-Network pharmacies can bill You for the difference between the amount charged and Our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum.

| Medical Benefits (*unless stated otherwise, a deductible applies*) | | What You Pay | |
|---|---|---|---|
| | | In-Network | Out-of-Network |
| Primary Care Visits (for Illness or Injury) | | First 3 Primary Care, Behavioral Health and Virtual Care visits combined, 0%<br><br>After 3 visits, 20% | 40% |
| Specialist Visits | | 20% | 40% |
| Urgent Care Visits | | 20% | 40% |
| Other Professional Services | | 20% | 40% |
| Preventive Care / Immunizations | Wellness Rewards available | Covered in full | 40% |
| Radiology and Laboratory - Outpatient | | 20% | 40% |
| Complex Imaging - Outpatient | CT / PET / SPECT scans, MRIs, MRAs, etc. | 20% | 40% |
| Acupuncture | 25 visits per calendar year | 20% | 40% |
| Ambulance Services | Air and Ground: services provided to the nearest hospital equipped to render the necessary treatment | 20%, In-Network deductible applies | |
| Ambulatory Surgical Center | | 10% | 40% |
| Behavioral Health - Inpatient | | 20% | 40% |
| Behavioral Health - Outpatient | | First 3 Primary Care, Behavioral Health and Virtual Care visits combined, 0%<br><br>After 3 visits, 20% per outpatient office / psychotherapy visit | 40% |
| Emergency Room | Facility and professional services | 20%, In-Network deductible applies | |
| Hearing Aids, Cochlear Implants and Assistive Listening Devices | Limitations apply<br>Excludes: routine hearing examinations, television caption decoder or cords | 20% | 40% |
| Hospital Care | See Ambulatory Surgical Center for cost reduction option | 20% | 40% |
| Maternity Care | | 20% | 40% |
| Neurodevelopmental Therapy | 20 visits per calendar year | 20% | 40% |
| Newborn Home Visits | Within 6 months of age, at least one visit during first 3 months, with up to 3 more available | Covered in full | Not covered |

| Medical Benefits (*unless stated otherwise, a deductible applies*) | | What You Pay | |
|---|---|---|---|
| | | In-Network | Out-of-Network |
| Rehabilitation Services - Inpatient | 30 days per calendar year | 20% | 40% |
| Rehabilitation Services - Outpatient | 20 visits per calendar year | 20% | 40% |
| Skilled Nursing Facility | 100 days per calendar year | 20% | 40% |
| Spinal Manipulations | 25 visits per calendar year | 20% | 40% |
| Virtual Care - Telehealth | Doctor visits via phone or video chat when not in a healthcare facility (includes Behavioral Health visits) | First 3 Primary Care, Behavioral Health and Virtual Care visits combined, 0%<br><br>After 3 visits<br>**Vendor: Doctor on Demand**<br>10%<br><br>**In-Network non-Vendor Provider:**<br>20% | 40% |

| Prescription Medication Benefits (*unless stated otherwise, a deductible applies*) | | What You Pay |
|---|---|---|
| Tier 1 | 90-day supply for retail or home delivery | $15 retail prescription / $30 home delivery prescription |
| Tier 2 | 90-day supply for retail or home delivery | $30 retail prescription / $60 home delivery prescription |
| Tier 3 | 90-day supply for retail or home delivery | $45 retail prescription / $90 home delivery prescription |
| Specialty Select | 30-day supply for retail | Refer to tiers 1, 2 and 3 above for specialty drugs |

*Deductible waived on retail or home delivery prescriptions for medications on the Optimum Value Medication List (OVML) located on Our website*
***Insulin Cost Share Cap:*** *Retail or home delivery: $35 cap on Member cost share per 30-day supply, deductible waived; $105 cap on Member cost share up to 90-day supply, deductible waived*
*20% for each self-administrable Cancer Chemotherapy medication*
*You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and / or coinsurance*
*More information about prescription drug coverage, including tier specific information, is available at https://regence.com/go/2025/OR/3tier*

| Value-Added Services | |
|---|---|
| Your Regence coverage includes access to the value-added services detailed here. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS.** For additional information regarding any of these value-added services, visit Our website or contact Customer Service. | |
| Joint, Spine, and Muscle Program | The Joint, Spine, and Muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles. |
| Kidney Health Management | If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD). |
| Mobile APP | Quick access to: ID card, chat with Customer Service, View Claims, Estimate Treatment Cost, Pharmacy pricing. |
| Nurse Advice | You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care 24 / 7. However, if You are experiencing a medical emergency, immediately call 911 instead. |
| Pregnancy Program | Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions; the Pregnancy Program can help. |
| Regence Advantages | Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. |
| Regence Empower | Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. Wellness Rewards available. |

| Out-of-Area Services |
|---|
| Outside of the service area, Members have In-Network benefits at Blue Cross and / or Blue Shield (Blue Plan) facilities across the country through the BlueCard® Program and worldwide through the Blue Cross Blue Shield Global® Core Program. Any other services will not be covered when processed through any Inter-Plan arrangements. Out-of-Network, You may be balance billed. Call 1 (800) 810 BLUE (2583) to learn how to get access. |

| Frequently Asked Questions | |
|---|---|
| How is my privacy protected? | Regence is committed to the confidentiality and security of Your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of Your personal information. You can view Our full privacy practices online at regence.com. |
| Is there a cost for "Covered in full"? | No, if Your benefit is covered in full there is no copay or deductible. |
| What if I need access to specialty care? Do I need a referral? | You can receive care from any In-Network provider without a referral. For some services, prior authorization may be required. |

This benefit summary provides a brief description of Your plan benefits, limitations and / or exclusions under Your plan and is not a guarantee of payment. Once enrolled, You can view Your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND / OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY**. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable

KAISER PERMANENTE®

# Summary of Dental Benefits

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

**Oregon** **1/1/2025 - 12/31/2025**

**Metro** **Group Number: 1543-043**

| **Benefit Maximum** per Calendar Year | |
|---|---|
| Per Member per Year | None |
| | **You pay** |
| **Dental Office Visit Charge** – per visit, plus any Cost Share shown below for specific Services | $10 |
| **Deductible** (Per Calendar Year; applies to all services unless otherwise indicated) | |
| For one Member per Year | $0 |
| For an entire Family per Year | $0 |
| **Preventive and Diagnostic Services** | |
| Oral exam | $0 |
| X-rays | $0 |
| Teeth cleaning | $0 |
| Fluoride | $0 |
| **Minor Restoration Services** | |
| Routine fillings | $0 |
| Plastic and steel crowns | $0 |
| Simple extractions | $0 |
| **Oral Surgery Services** | |
| Surgical tooth extractions | 20% Coinsurance |
| **Periodontics** | |
| Treatment of gum disease | 20% Coinsurance |
| Scaling and root planing | 20% Coinsurance |
| **Endodontics** | |
| Root canal therapy | 20% Coinsurance |
| **Major Restoration Services** | |
| Gold or porcelain crowns | 20% Coinsurance |
| Bridges | 20% Coinsurance |
| **Removable Prosthetic Services** | |
| Full upper and lower dentures | 20% Coinsurance |
| Partial dentures | 20% Coinsurance |
| Relines | 20% Coinsurance |
| Rebases | 20% Coinsurance |
| **Nitrous oxide** (Not subject to or counted toward the Deductible or Benefit Maximum) | |
| Adults and children age 13 years and older | $25 |
| Children age 12 years and younger | $0 |
| **Teledentistry** | |
| Telephone and video visits | $0 |

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| | |
|---|---|
| **Orthodontics** | Members age 17 years and younger: 50% of Charges up to Lifetime Benefit Maximum of $1,000, and 100% of Charges thereafter. Members age 18 years and older: No Coverage. |
| | |

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

**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit **kp.org** Portland area: 503-813-2000
All other areas: 1-800-813-2000. TTY, all areas: 711. Language Interpretation Services, all areas: 1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

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# 2025 Delta Dental Premier Benefit Summary

Delta Dental of Oregon & Alaska

## METRO

Group ID: 10001772

| | |
|---|---|
| **Calendar year costs** | |
| Calendar year maximum, per member (Class 2 and Class 3) | $2,000 |
| Calendar year deductible, per member | $50 |
| Calendar year deductible, per family | $150 |
| **Class 1* (Services do not apply to the calendar year max)** | |
| Periodic examinations / X-rays | 100% |
| Prophylaxis (cleanings) / periodontal maintenance | 100% |
| Sealants | 100% |
| Topical application of fluoride | 100% |
| **Class 2 - A** | |
| Restorative fillings | 100% |
| Space maintainers | 100% |
| Oral surgery (extractions & certain minor surgical procedures) | 100% |
| Endodontics (treatment of teeth with diseased or damaged nerves) | 100% |
| Periodontics (treatment of diseases of the gums and supporting structures of the teeth) | 100% |
| **Class 2 - B** | |
| Crowns and other cast restorations | 80% |
| Bridges (construction or repair of fixed bridges) | 80% |
| **Class 3** | |
| Implants | 50% |
| Dentures (construction or repair of partial and complete dentures) | 50% |
| **Orthodontics** | |
| Adult & Child orthodontic services | 50% up to $1,500 lifetime maximum |

* Deductible waived for Class 1 and Orthodontic services.

**This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.**

**How to use this dental plan**

When you visit your dental provider, tell them you are a Delta Dental member.

**When the member visits:**

**Delta Dental Premier Dentist:**

Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

**Non Participating Dentists:**

Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

**Limitations**
If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

**Preventive (Class 1 services)**
- **Diagnostic** Routine or comprehensive examinations or consultations are covered twice per year. Supplementary bitewing x-rays are covered once per year. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered twice per year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered twice per year for members under age 19. For members age 19 and older, topical application of fluoride is covered twice per year if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period.

**Basic (Class 2-A services)**
- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered for all teeth. A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

**Major (Class 2-B & Class 3 services)**
- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal guard** (night guard) covered at 100% once in a five year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouthguard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

**Exclusions**
- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in the dentist's office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed appointment charges.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

This is a summary of the dental plan benefits and is not a contract. If there is any discrepancy between the information in this summary and the contract, it is the contract that will control. Dental plans in Oregon provided by Oregon Dental Service dba Delta Dental Plan of Oregon. Delta Dental is a trademark of Delta Dental Plans Association.

DELTA DENTAL
Delta Dental of Oregon & Alaska

# A Look at Your VSP Vision Coverage

**With VSP and METRO, your health comes first.**

**As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.**

**Value and savings you love.**
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

**Provider choices you want.**
With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

**Shop online and connect your benefits.**
Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

**Quality vision care you need.**
You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

**Using your benefit is easy!**
Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP.

vsp vision care

## More Ways to Save

**Extra**
$20
**to spend on Featured Frame Brands†**

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

See all brands and offers at **vsp.com/offers**.

+

**Up to**
40%
**Savings on lens enhancements‡**

Create an account today.
Contact us: **800.877.7195** or **vsp.com**

## Your VSP Vision Benefits Summary

METRO and VSP provide you with an affordable vision plan.

**PROVIDER NETWORK:**
VSP Signature
**EFFECTIVE DATE:**
01/01/2025

vsp vision care

| BENEFIT | DESCRIPTION | COPAY | FREQUENCY |
|---|---|---|---|
| **Your Coverage with a VSP Provider** | | | |
| **WELLVISION EXAM** | • Focuses on your eyes and overall wellness<br>• Routine retinal screening | $15 for exam and glasses<br>Up to $39 | Every calendar year |
| **ESSENTIAL MEDICAL EYE CARE** | • Retinal imaging for members with diabetes covered-in-full<br>• Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.<br>• Coordination with your medical coverage may apply. Ask your VSP network doctor for details. | $20 per exam | Available as needed |
| **PRESCRIPTION GLASSES** | | | |
| **FRAME**† | • $190 Featured Frame Brands allowance<br>• $170 frame allowance<br>• 20% savings on the amount over your allowance<br>• $170 Walmart/Sam's Club frame allowance<br>• $95 Costco frame allowance | Combined with exam | Every other calendar year |
| **LENSES** | • Single vision, lined bifocal, and lined trifocal lenses<br>• Impact-resistant lenses for dependent children | Combined with exam | Every calendar year |
| **LENS ENHANCEMENTS** | • Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 40% on other lens enhancements | $0<br>$80 - $90<br>$120 - $160 | Every calendar year |
| **CONTACTS (INSTEAD OF GLASSES)** | • $170 allowance for contacts; copay does not apply<br>• Contact lens exam (fitting and evaluation) | Up to $60 | Every calendar year |
| **COMPUTER VISIONCARE (EMPLOYEE-ONLY COVERAGE)** | | | |
| **COMPUTER VISION EXAM** | • Evaluates your needs related to computer use | $10 for exam and glasses | Every calendar year |
| **FRAME**† | • $110 Featured Frame Brands allowance<br>• $90 frame allowance<br>• 20% savings on the amount over your allowance | Combined with exam | Every other calendar year |
| **LENSES** | • Single vision, lined bifocal, lined trifocal, and occupational lenses | Combined with exam | Every calendar year |
| **ADDITIONAL SAVINGS** | **Glasses and Sunglasses**<br>• Discover all current eyewear offers and savings at **vsp.com/offers**.<br>• 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam. | | |
| | **Laser Vision Correction**<br>• Average of 15% off the regular price; discounts available at contracted facilities.<br>• After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor | | |
| | **Exclusive Member Extras for VSP Members**<br>• Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**.<br>• Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details.<br>• Enjoy everyday savings on health, wellness, and more with VSP Simple Values. | | |
| **YOUR COVERAGE GOES FURTHER IN-NETWORK** | | | |
| With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider. | | | |

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.