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

Washington DED PLAN VC 3000/40/30%/6000 **1/1/2024 - 12/31/2024**

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)	$3,000
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$3,000
Family Deductible per Year (for an entire Family)	$6,000
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$6,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$6,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$12,000
Office Visits	**You pay**
Routine preventive physical exam	$0
Telehealth (phone/video)	$0 *
Primary Care	$40 not subject to Deductible for first 3 visits; then $40 after Deductible for additional visits in the same Year *
Specialty Care	$40 after Deductible
Urgent Care	$40 after Deductible
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$15 per department visit
X-ray, imaging, and special diagnostic procedures	30% Coinsurance after Deductible
CT, MRI, PET scans	30% Coinsurance after Deductible
Medications (outpatient)	**You pay**
Prescription drugs (up to a 30-day supply)	Rider Available for Purchase
Mail Order Prescription drugs (up to a 90-day supply)	
Administered medications, including injections (all outpatient settings)	30% Coinsurance after Deductible
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	30% Coinsurance after Deductible
Inpatient Hospital Services	30% Coinsurance after Deductible
Hospital Services	**You pay**
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency services	30% Coinsurance after Deductible
Inpatient Hospital Services	30% Coinsurance after Deductible

Outpatient Services (other)	**You pay**
Outpatient surgery visit	30% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$40 after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per Year)	$40 after Deductible
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Year)	30% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	**You pay**
Outpatient Services	$40 per visit not subject to Deductible for first 3 visits; then $40 per visit after Deductible for additional visits in the same Year *
Inpatient hospital & residential Services	30% Coinsurance after Deductible
Alternative Care (self-referred)	**You pay**
Acupuncture Services (up to 12 visits per Year)	$40 after Deductible
Chiropractic Services (up to 12 visits per Year)	$40 after Deductible
Massage Therapy	Rider Available for Purchase
Naturopathic Medicine	$40 not subject to Deductible for first 3 visits; then $40 after Deductible for additional visits in the same Year *
Hearing Instruments (includes hearing aids and bone-anchored hearing devices)	**You pay**
$3,000 allowance for each hearing instrument per ear every 36 months	$0, then any amount by which price exceeds allowance
Vision Services	**You pay**
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	$40 after Deductible
Vision hardware and optical Services (Covered until the end of the month in which Member turns 19 years of age.)	Rider Available for Purchase
Routine eye exam (For members 19 years and older.)	$40 after Deductible
Vision hardware and optical Services (For members 19 years and older.)	Rider Available for Purchase

[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 telehealth Services for primary care, mental health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.

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

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.