

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 DUAL CHOICE PPO PLAN VC 2500/40/20%/6500

1/1/2024 - 12/31/2024

	In-Network Providers	Out-of-Network Providers ¹
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.		
Deductible		
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.		
Self-only Deductible per Year (for a Family of one Member)	\$2,500	\$5,000
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$2,500	\$5,000
Family Deductible per Year (for an entire Family)	\$5,000	\$15,000
Out-of-Pocket Maximum ²		
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$6,500	\$13,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$6,500	\$13,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$13,000	\$27,000
Office Visits		
	You pay	
Routine preventive physical exam	\$0	40% Coinsurance after Deductible
Telehealth (phone/video)	\$0 *	40% Coinsurance after Deductible
Primary Care	\$60 not subject to Deductible for first 3 visits; then \$60 after Deductible for additional visits in the same Year *	40% Coinsurance after Deductible
	Enhanced Benefit ³ : \$40 not subject to Deductible for first 3 visits; then \$40 after Deductible for additional visits in the same Year *	
Specialty Care	\$60 after Deductible Enhanced Benefit ³ : \$40 after Deductible	40% Coinsurance after Deductible
Urgent Care	\$60 after Deductible Enhanced Benefit ³ : \$40 after Deductible	40% Coinsurance after Deductible

Tests (outpatient)		You pay
Preventive Tests	\$0	40% Coinsurance after Deductible
Laboratory	\$15 per department visit	40% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible	40% Coinsurance after Deductible
CT, MRI, PET scans	20% Coinsurance after Deductible	40% 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)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Nurse treatment room visits to receive injections	\$10	40% Coinsurance after Deductible
Maternity Care		You pay
Scheduled prenatal care visits and postpartum visit	\$0	40% Coinsurance after Deductible
Laboratory	\$15 per department visit	40% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible	40% 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	40% Coinsurance after Deductible
Outpatient Services (other)		You pay
Outpatient surgery visit	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	\$60 after Deductible Enhanced Benefit ³ : \$40 after Deductible	40% Coinsurance after Deductible
Durable medical equipment	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per Year)	\$60 after Deductible Enhanced Benefit ³ : \$40 after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility Services		You pay
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services		You pay
Outpatient Services	\$60 per visit not subject to Deductible for first 3 visits; then \$60 per visit after Deductible for additional visits in the same Year * Enhanced Benefit ³ : \$40 per visit not subject to Deductible for first 3 visits; then \$40 per visit after Deductible for additional visits in the same Year *	40% Coinsurance after Deductible
Inpatient hospital & residential Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Alternative Care (self-referred)		You pay
Acupuncture Services (up to 12 visits per Year)	\$40 after Deductible	40% Coinsurance after Deductible
Chiropractic Services (up to 12 visits per Year)	\$40 after Deductible	40% Coinsurance 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 *	40% Coinsurance after Deductible

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.)	\$60 after Deductible Enhanced Benefit ³ : \$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.)	\$60 after Deductible Enhanced Benefit ³ : \$40 after Deductible
Vision hardware and optical Services (For members 19 years and older.)	Rider Available for Purchase

¹ Out-of-network 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 an in-network hospital or ambulatory surgical center. For additional information, visit <https://healthy.kaiserpermanente.org/oregon-washington/support/pay-bills/medical-bills/no-surprises-act>.

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 select 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/dualchoice/nw for a searchable provider directory.

* 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 received from all In-Network 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 EOCs are available upon request, or you may go to kp.org/plandocuments.

Questions? Call Customer Service at 1-866-616-0047 (M-F, 8 am-6 pm) or visit kp.org.

TTY, all areas: 711. Language Interpretation Services, all areas: 1-800-324-8010

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