

# 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 HDHP PLAN A 1600/10%/2500**

**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** (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)	\$1,600
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$3,200
Family Deductible per Year (for an entire Family)	\$3,200

**Out-of-Pocket Maximum** <sup>1</sup> (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)	\$2,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$5,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	\$5,000

Office Visits	You pay
Routine preventive physical exam	\$0
Telehealth (phone/video)	\$0 after Deductible
Primary Care	10% Coinsurance after Deductible
Specialty Care	10% Coinsurance after Deductible
Urgent Care	10% Coinsurance after Deductible

Tests (outpatient)	You pay
Preventive Tests	\$0
Laboratory	10% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible
CT, MRI, PET scans	10% 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)	10% Coinsurance after Deductible
Nurse treatment room visits to receive injections	10% Coinsurance after Deductible

Maternity Care	You pay
Scheduled prenatal care visits and postpartum visits	\$0
Laboratory	10% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible
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

<b>Outpatient Services (other)</b>	<b>You pay</b>
Outpatient surgery visit	10% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	10% Coinsurance after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per Year)	10% Coinsurance after Deductible
<b>Skilled Nursing Facility Services</b>	<b>You pay</b>
Inpatient skilled nursing Services (up to 100 days per Year)	10% Coinsurance after Deductible
<b>Mental Health and Substance Use Disorder Services</b>	<b>You pay</b>
Outpatient Services	10% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible
<b>Alternative Care (self-referred)</b>	<b>You pay</b>
Acupuncture Services (up to 12 visits per Year)	10% Coinsurance after Deductible
Chiropractic Services (up to 12 visits per Year)	10% Coinsurance after Deductible
Massage Therapy	Rider Available for Purchase
Naturopathic Medicine	10% Coinsurance after Deductible
<b>Hearing Instruments (includes hearing aids and bone-anchored hearing devices)</b>	<b>You pay</b>
\$3,000 allowance for each hearing instrument per ear every 36 months	\$0 after meeting \$1,600 of the self-only Deductible or \$3,200 of the individual Family Member or Family Deductible, then any amount by which price exceeds allowance
<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.)	10% Coinsurance 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.)	10% Coinsurance after Deductible
Vision hardware and optical Services (For members 19 years and older.)	Rider Available for Purchase

<sup>1</sup> Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.

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>.

**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit [kp.org](https://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.