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

Added Choice Contact Center: 1-866-616-0047

Washington **1/1/2022 - 12/31/2022**

POS HDHP EE 2800/10%/5600

	Select Providers	PPO Providers	Non-Participating Providers [1]
Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.			
Deductible			
For Services that are subject to the Deductible, the amounts you pay for covered Services from Select Providers also count toward the Deductible for Services from PPO Providers, and vice versa. The amounts you pay for Services from Non-Participating Providers only count toward the Deductible for Services from Non-Participating Providers.			
Self-only Deductible per Year (for a Family of one Member)	$2,800	$3,600	$4,600
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$2,800	$3,600	$4,600
Family Deductible per Year (for an entire Family)	$5,600	$7,200	$9,200
Out-of-Pocket Maximum [2]			
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$5,600	$6,200	$9,200
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$5,600	$6,200	$9,200
Family Out-of-Pocket Maximum per Year (for an entire Family)	$11,200	$12,400	$18,400
Office Visits		**You pay**	
Routine preventive physical exam	$0	$0	30% Coinsurance after Deductible
Telehealth (phone/video)	$0 after Deductible	$0 after Deductible	30% Coinsurance after Deductible
Primary Care	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Specialty Care	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Tests (outpatient)		**You pay**	
Preventive Tests	$0	$0	30% Coinsurance after Deductible
Laboratory	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
CT, MRI, PET scans	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible

Medications (outpatient)		**You pay**	
Prescription drugs (up to a 30 day supply)	Not Covered	At MedImpact Pharmacy Not Covered	
Mail Order Prescription drugs (up to a 90 day supply)	Not Covered	MedImpact Mail-Order call CVS Caremark 1-800-237-2767	
Administered medications, including injections (all outpatient settings)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Nurse treatment room visits to receive injections	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Maternity Care		**You pay**	
Scheduled prenatal care visits and postpartum visit	$0	$0	30% Coinsurance after Deductible
Laboratory	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospital Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% 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	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Services (other)		**You pay**	
Outpatient surgery visit	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Durable medical equipment	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Physical, speech, and occupational therapies (20 visits per Year)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Skilled Nursing Facility Services		**You pay**	
Inpatient skilled nursing Services (up to 100 days per Year)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental Health and Chemical Dependency Services		**You pay**	
Outpatient Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient hospital & residential Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Alternative Care (self-referred)		**You pay**	
Acupuncture Services (up to 12 visits per Year)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Chiropractic Services (up to 12 visits per Year)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Massage Therapy	Not Covered	Not Covered	Not Covered
Naturopathic Medicine	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible

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Vision Services	You pay		
Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% 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		Not covered
Routine eye exam (For members 19 years and older.)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Vision hardware and optical Services (For members 19 years and older.)	Not Covered		

[1] Non-Participating Providers may be subject to balance billing.

[2] 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 **http://www.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..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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