# 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

Member Services: 1-800-813-2000

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

**TRAD PLAN C 20/2000**

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) | None |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | None |
| Family Deductible per Year (for an entire Family) | None |
| **Out-of-Pocket Maximum** [1] | |
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | $2,000 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | $2,000 |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | $4,000 |
| **Office Visits** | **You pay** |
| Routine preventive physical exam | $0 |
| Telehealth (phone/video) | $0 |
| Primary Care | $20 |
| Specialty Care | $30 |
| Urgent Care | $40 |
| **Tests (outpatient)** | **You pay** |
| Preventive Tests | $0 |
| Laboratory | $20 per department visit |
| X-ray, imaging, and special diagnostic procedures | $20 per department visit |
| CT, MRI, PET scans | $50 per department visit |
| **Medications (outpatient)** | **You pay** |
| Prescription drugs (up to a 30 day supply) | Not Covered |
| Mail Order Prescription drugs (up to a 90 day supply) | Not Covered |
| Administered medications, including injections (all outpatient settings) | 20% Coinsurance |
| Nurse treatment room visits to receive injections | $10 |
| **Maternity Care** | **You pay** |
| Scheduled prenatal care visits and postpartum visits | $0 |
| Laboratory | $20 per department visit |
| X-ray, imaging, and special diagnostic procedures | $20 per department visit |
| Inpatient Hospital Services | $200 per day up to $1,000 per admission |

| **Hospital Services** | **You pay** |
|---|---|
| Ambulance Services (per transport) | $75 |
| Emergency services | $200 (Waived if admitted) |
| Inpatient Hospital Services | $200 per day up to $1,000 per admission |
| **Outpatient Services (other)** | **You pay** |
| Outpatient surgery visit | $50 |
| Chemotherapy/radiation therapy visit | $30 |
| Durable medical equipment | 20% Coinsurance |
| Physical, speech, and occupational therapies (20 visits per Year) | $30 |
| **Skilled Nursing Facility Services** | **You pay** |
| Inpatient skilled nursing Services (up to 100 days per Year) | $0 |
| **Mental Health and Chemical Dependency Services** | **You pay** |
| Outpatient Services | $20 per visit |
| Inpatient hospital & residential Services | $200 per day up to $1,000 per admission |
| **Alternative Care** (self-referred) | **You pay** |
| Acupuncture Services (up to 12 visits per Year) | $30 per visit |
| Chiropractic Services (up to 12 visits per Year) | $30 per visit |
| Massage Therapy | Not Covered |
| Naturopathic Medicine | $20 per visit |
| **Vision Services** | **You pay** |
| Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.) | $20 |
| 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 |
| 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.

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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