# 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

Customer Service: 1-866-616-0047

**Washington DUAL CHOICE PPO PLAN I**
**3500/30/20%/8000**

**1/1/2023 - 12/31/2023**

| | 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) | $3,500 | $5,500 |
| Individual Family Member Deductible per Year (for each Member in a Family of two or more Members) | $3,500 | $5,500 |
| Family Deductible per Year (for an entire Family) | $10,500 | $16,500 |
| **Out-of-Pocket Maximum** [2] | | |
| Self-only Out-of-Pocket Maximum per Year (for a Family of one Member) | $8,000 | $15,000 |
| Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members) | $8,000 | $15,000 |
| Family Out-of-Pocket Maximum per Year (for an entire Family) | $16,000 | $30,000 |
| **Office Visits** | **You pay** | |
| Routine preventive physical exam | $0 | 40% Coinsurance after Deductible |
| Telehealth (phone/video) | $0 | 40% Coinsurance after Deductible |
| Primary Care | $50<br>Enhanced Benefit [3]: $30 | 40% Coinsurance after Deductible |
| Specialty Care | $60<br>Enhanced Benefit [3]: $40 | 40% Coinsurance after Deductible |
| Urgent Care | $100<br>Enhanced Benefit [3]: $50 | 40% Coinsurance after Deductible |
| **Tests (outpatient)** | **You pay** | |
| Preventive Tests | $0 | 40% Coinsurance after Deductible |
| Laboratory | $30 per department visit | 40% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | $30 per department visit | 40% Coinsurance after Deductible |
| CT, MRI, PET scans | $100 per department visit | 40% Coinsurance after Deductible |

| **Medications (outpatient)** | **You pay** | |
|---|---|---|
| Prescription drugs (up to a 30 day supply) | Kaiser Permanente Pharmacy:<br>Not Covered<br>MedImpact Pharmacy:<br>Not Covered | |
| Mail Order Prescription drugs (up to a 90 day supply) | Kaiser Permanente Pharmacy:<br>Not Covered<br>MedImpact:<br>call CVS Caremark 1-800-237-2767 | |
| 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 | $30 per department visit | 40% Coinsurance after Deductible |
| X-ray, imaging, and special diagnostic procedures | $30 per department visit | 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<br>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<br>Enhanced Benefit [3]: $40 | 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 | $50 per visit<br>Enhanced Benefit [3]: $30 per visit | 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 per visit | 40% Coinsurance after Deductible |
| Chiropractic Services (up to 12 visits per Year) | $40 per visit | 40% Coinsurance after Deductible |
| Massage Therapy | Not Covered | Not Covered |
| Naturopathic Medicine | $30 | 40% Coinsurance after Deductible |
| **Vision Services** | **You pay** | |
| Routine eye exam (Covered until the end of the month in which Member turns 19 years of age.) | $50<br>Enhanced Benefit [3]: $30 | 40% 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.) | $50<br>Enhanced Benefit [3]: $30 | 40% Coinsurance after Deductible |
| Vision hardware and optical Services (For members 19 years and older.) | Not Covered | |

[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.

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 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.