




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.kp.org/wa or by calling 1-888-901-4636. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-888-901-4636 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$200 individual/\$600 family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Does not apply to <u>preventive care</u> , <u>prescription drugs</u> , <u>emergency medical transportation</u> , <u>durable medical equipment</u> and eye exams.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,000 individual/\$6,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket</u> limits until the overall family <u>out-of-pocket</u> limit has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, hospital <u>copayments</u> , benefit-specific <u>coinsurances</u> except <u>emergency medical transportation</u> , <u>prescription drug copayments</u> , <u>deductible</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.kp.org/wa or call 1-888-901-4636 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes. See www.kp.org/wa or call 1-888-901-4636 for a list of <u>specialist</u> providers.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copayment</u> /visit	Not covered	Manipulative therapy limited to 10 visits per calendar year, and naturopathy limited to 3 visits per medical diagnosis per calendar year, additional visits are covered with <u>preauthorization</u> or will not be covered. Acupuncture limited to 8 visits per medical diagnosis per calendar year, additional visits are covered with <u>preauthorization</u> .
	<u>Specialist</u> visit	\$15 <u>copayment</u> /visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	\$15 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not covered	Services must be in accordance with the Kaiser Permanente well-care schedule. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	High end radiology imaging services such as CT, MRI and PET require <u>preauthorization</u> or will not be covered.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/wa .	Preferred generic drugs	\$15 <u>copayment/prescription</u> <u>Deductible</u> does not apply	Not covered	Covers up to a 30-day supply Does not apply to <u>out-of-pocket</u> maximum.
	Preferred brand drugs	\$30 <u>copayment/prescription</u> <u>Deductible</u> does not apply	Not covered	Covers up to a 30-day supply Does not apply to <u>out-of-pocket</u> maximum.
	Non-preferred generic/brand drugs	Not covered	Not covered	None
	Mail-order drugs	Member pays two times the <u>prescription drug cost share</u> <u>Deductible</u> does not apply	Available when dispensed through the Kaiser Permanente designated mail order service.	Covers up to a 90-day supply Does not apply to <u>out-of-pocket</u> maximum.
If you have outpatient	Facility fee (e.g., ambulatory)	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
surgery	surgery center)			
	Physician/surgeon fees	\$15 <u>copayment</u> /visit	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copayment</u>	\$150 <u>copayment</u>	Notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible, <u>copayment</u> is waived if admitted.
	<u>Emergency medical transportation</u>	20% benefit specific <u>coinsurance</u> <u>Deductible</u> does not apply	20% benefit specific <u>coinsurance</u> <u>Deductible</u> does not apply	None
	<u>Urgent care</u>	\$15 <u>copayment</u> /visit	\$150 <u>copayment</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Non-emergency inpatient services require <u>preauthorization</u> or will not be covered.
	Physician/surgeon fees	Included with Facility fee	Not covered	Non-emergency inpatient services require <u>preauthorization</u> or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copayment</u> /visit	Not covered	None
	Inpatient services	No charge	Not covered	Non-emergency inpatient services require <u>preauthorization</u> or will not be covered.
If you are pregnant	Office visits	\$15 <u>copayment</u> /visit	Not covered	Routine care is covered as <u>preventive care</u> and not subject to the <u>copayment</u> .
	Childbirth/delivery professional services	Included with Facility fee	Not covered	Notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible.
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge <u>Deductible</u> does not apply	Not covered	Requires <u>preauthorization</u> or will not be covered.
	<u>Rehabilitation services</u>	\$15 <u>copayment</u> /visit for outpatient No charge for inpatient	Not covered	Limited to 60 visits per calendar year/outpatient. Limited to 60 days per calendar year/inpatient. (combined limit with <u>Habilitation services</u>). Services with mental health diagnoses are covered with no limit.
	<u>Habilitation services</u>	\$15 <u>copayment</u> /visit for outpatient	Not covered	Limited to 60 visits per calendar year/outpatient. Limited to 60 days per calendar year/inpatient. (combined limit with

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
		No charge for inpatient		<u>Rehabilitation services</u>). Services with mental health diagnoses are covered with no limit.
	<u>Skilled nursing care</u>	No charge	Not covered	Limited to 60 days per calendar year. Requires <u>preauthorization</u> or will not be covered.
	<u>Durable medical equipment</u>	20% benefit-specific <u>coinsurance</u> <u>Deductible</u> does not apply	Not covered	Requires <u>preauthorization</u> or will not be covered. Does not apply to <u>out-of-pocket</u> maximum.
	<u>Hospice services</u>	No charge <u>Deductible</u> does not apply	Not covered	Requires <u>preauthorization</u> or will not be covered.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copayment</u> /visit <u>Deductible</u> does not apply	Not covered	Limited to one exam every 12 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$1,000 per ear/36 months)
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Washington Office of Insurance Commissioner at: www.insurance.wa.gov/your-insurance/health-insurance/appeal. The Insurance Consumer Hotline at 1-800-562-6900 or access to a page to email the same office: www.insurance.wa.gov/ask-us-insurance-question. Or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-901-4636.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-901-4636.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-901-4636.

----- *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* -----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$200
- Specialist copayment \$15
- Hospital (facility) coinsurance 0%
- Other (blood work) coinsurance 0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$300

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$200
- Specialist copayment \$15
- Hospital (facility) coinsurance 0%
- Other (blood work) coinsurance 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,480

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$200
- Specialist copayment \$15
- Hospital (facility) coinsurance 0%
- Other (x-ray) coinsurance 0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$390