
 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, see www.kp.org/plandocuments or call 1-888-901-4636 (TTY: 711). 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 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network Provider</u> : \$500 Individual / \$1,000 Family; <u>Non-Network Provider</u> : \$500 Individual / \$1,000 Family	Generally, you must pay all of the costs from <u>providers</u> 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>?	Yes. <u>Preventive care</u> and services indicated in chart starting on page 2.	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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes, Non-network <u>emergency room care</u> .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Not Applicable	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u>?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u>?	Yes. See www.kp.org/wa or call 1-888-901-4636 (TTY: 711) 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 <u>plan's 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 <u>provider's</u> 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, but you may self-refer to certain <u>specialists</u> .	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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge	20% coinsurance	None
	Specialist visit	No charge	20% coinsurance	None
	Preventive care/screening/immunization	No charge, deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Preauthorization required or will not be covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/wa	Preferred generic drugs	\$10 (retail & mail order)/ prescription , deductible does not apply.	\$15 or 20% coinsurance (retail) whichever is greater / prescription , deductible does not apply	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs	\$10 (retail & mail order)/ prescription , deductible does not apply.	\$15 or 20% coinsurance (retail) whichever is greater / prescription , deductible does not apply	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	Applicable Preferred generic or Preferred brand cost shares apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through the exception process.
	Specialty drugs	Applicable Preferred generic or Preferred brand cost shares apply.	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need	Emergency room care	\$50 / visit	\$50 / visit	You must notify Kaiser Permanente within 24

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		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
immediate medical attention				hours if admitted to a <u>Non-network provider</u> ; limited to initial emergency only.
	Emergency medical transportation	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	None
	Urgent care	No charge	20% <u>coinsurance</u>	<u>Non-Network providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <u>coinsurance</u>	<u>Preauthorization</u> required or will not be covered.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Preauthorization</u> required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% <u>coinsurance</u>	None
	Inpatient services	No charge	20% <u>coinsurance</u>	<u>Preauthorization</u> required or will not be covered.
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.
	Childbirth/delivery facility services	No charge	20% <u>coinsurance</u>	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.
If you need help recovering or have other special health needs	Home health care	No charge, <u>deductible</u> does not apply.	20% <u>coinsurance</u>	<u>Preauthorization</u> required or will not be covered.
	Rehabilitation services	Outpatient: No charge Inpatient: No charge	20% <u>coinsurance</u>	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with <u>Habilitation services</u>). Services with mental health

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)	
				diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered.
	Habilitation services	Outpatient: No charge Inpatient: No charge	20% <u>coinsurance</u>	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with <u>Rehabilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered.
	Skilled nursing care	No charge	20% <u>coinsurance</u>	60-day limit / year. <u>Preauthorization</u> required or will not be covered.
	Durable medical equipment	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Subject to <u>formulary</u> guidelines. <u>Preauthorization</u> required or will not be covered.
	Hospice services	No charge, <u>deductible</u> does not apply.	20% <u>coinsurance</u>	<u>Preauthorization</u> required or will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam	Not covered	Limited to 1 exam / 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 .)		
<ul style="list-style-type: none"> • Bariatric surgery • Children's glasses • Cosmetic surgery • Dental care (Adult and child) 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Acupuncture (5 visit limit / year) 	<ul style="list-style-type: none"> • Chiropractic care (10 visit limit / year) 	<ul style="list-style-type: none"> • 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 shown in the chart below. 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 on how 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 agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-888-901-4636 (TTY:711) or www.kp.org/wa
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 (TTY: 711).]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-901-4636 (TTY: 711).]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-901-4636 (TTY: 711).]

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	\$500
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other (blood work) copayment	\$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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$530

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other (blood work) copayment	\$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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$50
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$450

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other (x-ray) copayment	\$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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$60
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$860

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.