



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, 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 deductible ?	<u>Preferred provider</u> : \$750 Individual / \$1,500 Family Shared with <u>preferred provider</u> and <u>out-of-network provider networks</u>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan , 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 deductible ?	Yes. <u>Preventive care</u> and services indicated in chart starting on page 2.	This plan 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 plan 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 www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan ?	<u>Preferred provider</u> : \$3,000 Individual / \$6,000 Family Shared with <u>preferred provider</u> and <u>out-of-network provider networks</u>	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 plan , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this plan doesn't cover, and services indicated in chart starting on page 2.	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 network provider ?	Yes. See www.kp.org/wa or call 1-888-901-4636 (TTY: 711) for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network . 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 plan 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 referral to see a specialist ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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
		Preferred Provider (You will pay the least)	Out-of-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	10% (5% enhanced benefit) coinsurance	30% coinsurance	Enhanced benefit applies when services are provided by an Enhanced provider .
	Specialist visit	10% (5% enhanced benefit) coinsurance	30% coinsurance	None
	Preventive care/screening/immunization	No charge, deductible does not apply.	30% coinsurance	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)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% 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	\$15 or (\$10 enhanced) (retail); 2x retail cost share (mail order) / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs	\$25 or (\$20 enhanced) (retail); 2x retail cost share (mail order) / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	\$45 or (\$40 enhanced) (retail); 2x retail cost share (mail order) / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines .
	Specialty drugs	Applicable Preferred generic, Preferred brand or Non-Preferred 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	Facility fee (e.g., ambulatory surgery)	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
outpatient surgery	center)			
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	\$150 / visit, then 10% <u>coinsurance</u>	\$150 / visit, then 10% <u>coinsurance</u>	You must notify Kaiser Permanente within 24 hours if admitted to an <u>Out-of-network provider</u> ; limited to initial emergency only. <u>Copayment</u> waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	Urgent care	10% (5% enhanced benefit) <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	You must notify Kaiser Permanente of admission or will not be covered.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	You must notify Kaiser Permanente of admission or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% (5% enhanced benefit) <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	You must notify Kaiser Permanente of admission or will not be covered.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <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	10% <u>coinsurance</u>	30% <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	Home health care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	You must notify Kaiser Permanente or will not be covered.
	Rehabilitation services	Outpatient: 10% (5%	Outpatient: 30%	Combined with Habilitation services:

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
needs		enhanced benefit) <u>coinsurance</u> Inpatient: 10% <u>coinsurance</u>	<u>coinsurance</u> Inpatient: 30% <u>coinsurance</u>	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, <u>preauthorization</u> required or will not be covered.
	Habilitation services	Outpatient: 10% (5% enhanced benefit) <u>coinsurance</u> Inpatient: 10% <u>coinsurance</u>	Outpatient: 30% <u>coinsurance</u> Inpatient: 30% <u>coinsurance</u>	Combined with Rehabilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, <u>preauthorization</u> required or will not be covered.
	Skilled nursing care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	60-day limit / year. Limits are combined with preferred and <u>out-of-network provider networks</u> . You must notify Kaiser Permanente of admission or will not be covered.
	Durable medical equipment	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Subject to <u>formulary</u> guidelines. <u>Preauthorization</u> may be required or will not be covered
	Hospice services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	You must notify Kaiser Permanente of admission or will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam, <u>deductible</u> does not apply.	No charge for refractive exam, <u>deductible</u> does not apply.	Limited to 1 exam / 12 months
	Children's glasses	No charge, <u>deductible</u> does not apply.	Shared with <u>preferred provider network</u>	Members age 19 and over limited to \$250 / 24 months; Members under age 19 limited to 1 pair of frames and lenses / year or contact lenses covered at 50% <u>coinsurance</u>
	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 .)		
• Cosmetic surgery • Dental care (Adult and child) • 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 (12 visit limit / year) • Bariatric surgery	• Chiropractic care (15 visit limit / year) • Hearing aids (\$1,000 limit / 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 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): Dine'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	\$750
■ Specialist cost sharing	10%
■ Hospital (facility) coinsurance	10%
■ Other (blood work) coinsurance	10%

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	\$750
Copayments	\$10
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$1,880

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$750
■ Specialist cost sharing	10%
■ Hospital (facility) coinsurance	10%
■ Other (blood work) coinsurance	10%

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	\$750
Copayments	\$500
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,270

Mia's Simple Fracture

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

■ The plan's overall deductible	\$750
■ Specialist cost sharing	10%
■ Hospital (facility) coinsurance	10%
■ Other (x-ray) coinsurance	10%

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	\$750
Copayments	\$500
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,150

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