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 1-866-648-1928 (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 http://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?	$1,400 Individual / $2,800 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,100 Individual / $10,200 Family	The out-of-pocket limit 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org/wa or call 1-866-648-1928 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	10% coinsurance	Not covered	None
	Specialist visit	10% coinsurance	Not covered	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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	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.	Value based drugs Preferred generic drugs	Retail: $5 / prescription; Mail Order: $10 / prescription Retail: $20 / prescription; Mail Order: $40 / prescription	Not covered	Up to a 30-day supply (retail) or a 90 day-supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs	Retail: $40 / prescription; Mail Order: $80 / prescription	Not covered	Up to a 30-day supply (retail) or a 90 day-supply (mail order). Subject to formulary guidelines.
	Non-preferred generic/brand drugs	Retail: 50% coinsurance up to $250; Mail Order: 50% coinsurance up to $750	Not covered	Up to a 30-day supply (retail) or a 90 day-supply (mail order). Subject to formulary guidelines.
	Specialty drugs	Applicable preferred generic, preferred brand, or non-preferred generic/brand cost shares may apply.	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate	Emergency room care	10% coinsurance	10% coinsurance	You must notify Kaiser Permanente within 24

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)	
medical attention				hours if admitted to a Non-network provider; Limited to initial emergency only;
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	10% coinsurance	Non-network providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Preauthorization required or will not be covered.
	Physician/surgeon fees	10% coinsurance	Not covered	Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	Not covered	None
	Inpatient services	10% coinsurance	Not covered	Preauthorization required or will not be covered.
If you are pregnant	Office visits	10% coinsurance	Not covered	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible.
	Childbirth/delivery facility services	10% coinsurance	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Preauthorization required or will not be covered.
	Rehabilitation services	Outpatient: 10% coinsurance Inpatient: 10% coinsurance	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60 day limit / year (combined limit with Habilitation services). Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered.
	Habilitation services	Outpatient: 10% coinsurance Inpatient: 10% coinsurance	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60 day limit / year (combined limit with Rehabilitation services). Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered.
	Skilled nursing care	10% coinsurance	Not covered	150 day limit / calendar year. Preauthorization

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)	
				required or will not be covered.
	Durable medical equipment	10% coinsurance	Not covered	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	10% coinsurance	Not covered	Preauthorization required or will not be covered.
If your child needs dental or eye care	Children's eye exam	10% coinsurance	Not covered	Limited to one exam / 12 months
	Children's glasses	No charge	Not covered	Members age 19 and over limited to $150 every 24 months. Members under age 19 limited to 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance.
	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
- 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 (10 visit limit / year)
- Dental care (Adult & Child)
- Hearing aids ($800 / 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 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	1-866-648-1928 (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

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 (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, kwiijigo 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	$1,400
Specialist coinsurance	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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$40
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,400

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

The plan's overall deductible	$1,400
Specialist coinsurance	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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$1,300
Coinsurance	$50
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,810

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

The plan's overall deductible	$1,400
Specialist coinsurance	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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,450

The plan would be responsible for the other costs of these EXAMPLE covered services.