
 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](http://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 <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 <u>deductible</u> ?	<u>Preferred Provider</u> : \$750 Individual / \$2,250 Family <u>Out-of-Network Provider</u> : \$1,500 Individual / \$4,500 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a> .
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> ?	<u>Preferred Provider</u> : \$3,500 Individual / \$7,000 Family <u>Out-of-Network Provider</u> : \$7,000 Individual / \$14,000 Family	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> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> 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 <u>network provider</u> ?	Yes. See <a href="http://www.kp.org/wa">www.kp.org/wa</a> 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> ?	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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 (\$15 enhanced benefit) / visit <u>Deductible</u> does not apply	50% <u>coinsurance</u>	Enhanced benefit applies when services are provided by an Enhanced <u>provider</u> . Primary care <u>copayments</u> are waived for all outpatient services through the age of 17.
	<u>Specialist</u> visit	\$35 (\$25 enhanced benefit) / visit <u>Deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	Not covered	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)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient diagnostic laboratory and radiology services are covered in full up to a \$500 allowance / year
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required or will not be covered. Outpatient diagnostic laboratory and radiology services are covered in full up to a \$500 allowance / year
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.kp.org/wa">www.kp.org/wa</a> .	Preferred generic drugs	Retail: \$10 (\$5 enhanced benefit) / prescription; Mail Order 2x Retail <u>cost share</u> / prescription <u>Deductible</u> does not apply	Not covered	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to <u>formulary</u> guidelines.
	Preferred brand drugs	Retail: \$50 (\$40 enhanced benefit) / prescription; Mail Order 2x Retail <u>cost share</u> / prescription <u>Deductible</u> does not apply	Not covered	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to <u>formulary</u> guidelines.
	Non-preferred generic/brand drugs	Retail: 50% <u>coinsurance</u> up to \$125 / prescription; Mail Order 2x Retail <u>cost share</u> / prescription <u>Deductible</u> does not apply	Not covered	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to <u>formulary</u> guidelines.
	<u>Specialty drugs</u>	Retail: 50% <u>coinsurance</u>	Not covered	Up to a 30-day supply (retail). Subject to

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)	
		up to \$150 / prescription <u>Deductible</u> does not apply		<u>formulary</u> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit, 20% <u>coinsurance</u>	\$150 / visit, 20% <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.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$25 (\$15 enhanced benefit) / visit <u>Deductible</u> does not apply	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	You must notify Kaiser Permanente of admission or will not be covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <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	\$25 (\$15 enhanced benefit) / visit <u>Deductible</u> does not apply	50% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	You must notify Kaiser Permanente of admission or will not be covered.
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn 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)	
				<u>cost shares</u> are separate from that of the mother.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	130 visit limit / year. Limits combined with preferred and <u>out-of-network provider networks</u> . You must notify Kaiser Permanente or will not be covered.
	<u>Rehabilitation services</u>	Outpatient: \$35 (\$25 enhanced benefit) / visit <u>Deductible</u> does not apply Inpatient: 20% <u>coinsurance</u>	Outpatient: 50% <u>coinsurance</u> Inpatient: 50% <u>coinsurance</u>	Outpatient: 60 visit limit / year. Inpatient: 60 day limit / year (combined with <u>Habilitation services</u> ). Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Habilitation services</u>	Outpatient: \$35 (\$25 enhanced benefit) / visit <u>Deductible</u> does not apply Inpatient: 20% <u>coinsurance</u>	Outpatient: 50% <u>coinsurance</u> Inpatient: 50% <u>coinsurance</u>	Outpatient: 60 visit limit / year. Inpatient: 60 day limit / year (combined with <u>Rehabilitation services</u> ). Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	100 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.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Orthotics covered up to \$300 / year. Subject to <u>formulary</u> guidelines. <u>Preauthorization</u> may be required or will not be covered
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <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 <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply	Limited to one 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.)

- |                            |                         |                        |
|----------------------------|-------------------------|------------------------|
| • Routine eye care (Adult) | • Infertility treatment | • Private-duty nursing |
| • Cosmetic surgery         | • Long-term care        | • Routine foot care    |

- Dental care (Adult & Child)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Acupuncture (20 visit limit / year)
- Chiropractic care (20 visit limit / year)
- Massage therapy (20 visit limit / year)
- Hearing aids (\$400 / ear / 36 months)
- Bariatric surgery

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

**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, kwijjigo 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 copayment \$35
- Hospital (facility) coinsurance 20%
- Other (blood work) coinsurance 20%

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,730</b>

**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 copayment \$35
- Hospital (facility) coinsurance 20%
- Other (blood work) coinsurance 20%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,720</b>

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

- The plan's overall deductible \$750
- Specialist copayment \$35
- Hospital (facility) coinsurance 20%
- Other (x-ray) coinsurance 20%

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

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,150</b>