
 **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/plandocuments or by calling 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? | \$200 Individual / \$400 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 deductible? | 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 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? | \$2,500 Individual / \$5,000 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 out-of-pocket limit? | <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 network provider? | 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 <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 referral to see a specialist? | 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 | \$15 / visit <u>Deductible</u> does not apply | Not covered | None |
| | <u>Specialist</u> visit | \$30 / visit <u>Deductible</u> does not apply | Not covered | 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) | 10% <u>coinsurance</u> | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 10% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> required 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 | Retail: \$10 / 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: \$20 / 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 | Not covered | Not covered | None |
| | <u>Specialty drugs</u> | Retail: 50% <u>coinsurance</u> up to \$150 | Not covered | Up to a 30-day supply (retail). Subject to <u>formulary</u> guidelines. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$30 / visit, 10% <u>coinsurance</u> | Not covered | None |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | Not covered | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$50 / visit, 10% <u>coinsurance</u> | \$50 / visit, 10% <u>coinsurance</u> | You must notify Kaiser Permanente within 24 hours if admitted to a Non-network <u>provider</u> ; Limited to initial emergency only; <u>Copayment</u> is waived if admitted as an inpatient. |

| 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) | |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> <u>Deductible</u> does not apply | 20% <u>coinsurance</u> <u>Deductible</u> does not apply | None |
| | <u>Urgent care</u> | \$15 / visit <u>Deductible</u> does not apply | \$50 / visit, 10% <u>coinsurance</u> | Non- <u>network providers</u> covered when temporarily outside the service area. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> required or will not be covered. |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> required or will not be covered. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$15 / visit <u>Deductible</u> does not apply | Not covered | None |
| | Inpatient services | 10% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> required or will not be covered. |
| If you are pregnant | Office visits | 10% <u>coinsurance</u> | Not covered | <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 | 10% <u>coinsurance</u> | Not covered | 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> | Not covered | 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 | <u>Home health care</u> | No charge <u>Deductible</u> does not apply | Not covered | 130 visit limit / year. <u>Preauthorization</u> required or will not be covered. |
| | <u>Rehabilitation services</u> | Outpatient: \$30 / visit <u>Deductible</u> does not apply Inpatient: 10% <u>coinsurance</u> | Not covered | Outpatient: 45 visit limit / year. Inpatient: 30 day limit / year (combined with <u>Habilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered. |
| | <u>Habilitation services</u> | Outpatient: \$30 / visit <u>Deductible</u> does not apply | Not covered | Outpatient: 45 visit limit / year. Inpatient: 30 day limit / year (combined with <u>Rehabilitation</u> |

| 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) | |
| | | Inpatient: 10% <u>coinsurance</u> | | <u>services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered. |
| | <u>Skilled nursing care</u> | 10% <u>coinsurance</u> | Not covered | 60 day limit / year. <u>Preauthorization</u> required or will not be covered. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> <u>Deductible</u> does not apply | Not covered | Subject to <u>formulary</u> guidelines. <u>Preauthorization</u> required or will not be covered. |
| | <u>Hospice services</u> | No charge <u>Deductible</u> does not apply | Not covered | <u>Preauthorization</u> required or will not be covered. |
| If your child needs dental or eye care | Children's eye exam | \$15 / visit <u>Deductible</u> does not apply | Not covered | 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.)

- | | | |
|-------------------------------|--|------------------------|
| • Bariatric surgery | • Hearing aids | • Private-duty nursing |
| • Children's glasses | • Infertility treatment | • Routine foot care |
| • Cosmetic surgery | • Long-term care | • Weight loss programs |
| • Dental care (Adult & Child) | • Non-emergency care when traveling outside the U.S. | |

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) | • Chiropractic care (10 visit limit / year) | • 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 | 1-888-901-4636 (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

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, 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 \$200
- Specialist copayment \$30
- 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$200 |
| <u>Copayments</u> | \$30 |
| <u>Coinsurance</u> | \$900 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,190 |

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 \$30
- 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$200 |
| <u>Copayments</u> | \$1,000 |
| <u>Coinsurance</u> | \$30 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$1,290 |

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

- The plan's overall deductible \$200
- Specialist copayment \$30
- 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$200 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$600 |