**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?** | $3,000 Individual / $6,000 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 family 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?** | $8,150 Individual / $16,300 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 or call 1-888-901-4636 (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 | $40 / visit, deductible does not apply. | Not covered | None |
| | Specialist visit | $50 / visit, deductible does not apply. | 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 needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not covered | Preauthorization required |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.kp.org/formulary | Preferred generic drugs | $15 (retail); $30 (mail order) / prescription, deductible does not apply. | Not covered | Up to a 90-day supply (retail / mail order). No charge for contraceptives. Subject to formulary guidelines. |
| | Preferred brand drugs | $30 (retail); $60 (mail order) / prescription, deductible does not apply. | Not covered | Up to a 90-day supply (retail / mail order). Subject to formulary guidelines. |
| | Non-preferred drugs | Applicable preferred generic or Preferred brand cost shares apply. | Not covered | Up to a 90-day supply (retail / mail order). Subject to formulary guidelines , when approved through the exception process.. |
| | Specialty drugs | 50% coinsurance up to $300 (retail) / prescription, deductible does not 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) | 30% coinsurance | Not covered | None |
| | Physician/surgeon fees | 30% coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | $250 / visit, then 30% coinsurance | $250 / visit, then 30% coinsurance | You must notify Kaiser Permanente within 24 hours if admitted to a Non-network provider; limited to initial emergency only. Copayment waived if admitted directly to the hospital as |

| 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) | |
| | | | | an inpatient. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None |
| | Urgent care | $40 / visit, deductible does not apply. | $250 / visit, then 30% coinsurance | Non-network providers covered when temporarily outside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | Not covered | Preauthorization required |
| | Physician/surgeon fees | 30% coinsurance | Not covered | Preauthorization required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 / visit, deductible does not apply. | Not covered | None |
| | Inpatient services | 30% coinsurance | Not covered | Preauthorization required |
| **If you are pregnant** | Office visits | 30% coinsurance | Not covered | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 30% coinsurance | Not covered | You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother. |
| | Childbirth/delivery facility services | 30% coinsurance | Not covered | You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother. |
| **If you need help recovering or have other special health needs** | Home health care | No Charge, deductible does not apply. | Not covered | 130 visit limit / year. Preauthorization required |
| | Rehabilitation services | Outpatient: $50 / visit, deductible does not apply. Inpatient: 30% coinsurance | Not covered | Combined with Habilitation services: Outpatient: 45 visit limit / year. Inpatient: 30-day limit / year, preauthorization required. |
| | Habilitation services | Outpatient: $50 / visit, deductible does not apply. Inpatient: 30% coinsurance | Not covered | Combined with Rehabilitation services: Outpatient: 45 visit limit / year. Inpatient: 30-day limit / year, preauthorization required. |
| | Skilled nursing care | 30% coinsurance | Not covered | 60-day limit / year. Preauthorization required |

| 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) | |
| | Durable medical equipment | 30% coinsurance | Not covered | Subject to formulary guidelines. Preauthorization required |
| | Hospice services | No charge, deductible does not apply. | Not covered | Preauthorization required |
| **If your child needs dental or eye care** | Children's eye exam | $40 / visit for refractive exam, deductible does not apply. | 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.)**

- Bariatric surgery
- Children's glasses
- 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)
- Chiropractic care (12 visit limit / year)
- Hearing aids (1 aid / 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 |
| 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).
Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-888-901-4636 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4636 (TTY: 711).
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-888-901-4636 (TTY: 711) uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-901-4636 (TTY: 711).
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-901-4636 (TTY: 711).
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 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 | $3,000 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 30% |
| Other (blood work) coinsurance | 30% |

**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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,000 |
| Copayments | $10 |
| Coinsurance | $2,600 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$5,630** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 30% |
| Other (blood work) coinsurance | 30% |

**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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $40 |
| Copayments | $1,100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,140** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 30% |
| Other (x-ray) coinsurance | 30% |

**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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,100 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,400** |

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