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 1-888-901-4636 (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 deductible?	Preferred Provider: **$1,500** Individual / **$3,000** Family Out-of-Network Provider: **$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?	Preferred Provider: **$6,000** Individual / **$12,000** Family Out-of-Network Provider: **$12,000** Individual / **$24,000** 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 1-888-901-4636 (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?	**No.**	You can see the specialist you choose without a referral.

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	$30 ($20 enhanced benefit) / visit Deductible does not apply to office visits but does apply to office-based procedures and surgical services.	50% coinsurance	Enhanced benefit applies when services are provided by an Enhanced provider.
	Specialist visit	$60 ($40 enhanced benefit) / visit Deductible does not apply to office visits but does apply to office-based procedures and surgical services.	50% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible does not apply	50% coinsurance	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)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% 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	Retail: $10 / prescription; Mail Order: 2x retail cost share / prescription Deductible does not apply	Not covered	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs	Retail: $35 or ($30 enhanced) / prescription; Mail Order: 2x retail cost share / prescription Deductible does not apply	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: $70 or ($65 enhanced) / prescription; Mail Order: 2x retail cost	Not covered	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to formulary guidelines.

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)	
		share / prescription Deductible does not apply		
	Specialty drugs	Applicable preferred generic, preferred brand, or non-preferred generic/brand cost shares may apply. 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	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$50 / visit, 30% coinsurance	$50 / visit, 30% coinsurance	You must notify Kaiser Permanente within 24 hours if admitted to an out-of-network provider; limited to initial emergency only; Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$30 ($20 enhanced benefit) / visit Deductible does not apply to office visits but does apply to office-based procedures and surgical services.	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	You must notify Kaiser Permanente of admission or will not be covered.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	You must notify Kaiser Permanente of admission or will not be covered.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$30 ($20 enhanced benefit) / visit Deductible does not apply to office visits but does apply to office-based procedures and surgical services.	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	You must notify Kaiser Permanente of admission or will not be covered.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	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	30% coinsurance	50% coinsurance	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	50% coinsurance	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	30% coinsurance	50% coinsurance	130 visit limit / year. Limits combined with preferred and out-of-network provider networks. You must notify Kaiser Permanente or will not be covered.
	Rehabilitation services	Outpatient: $60 ($40 enhanced benefit) / visit Deductible does not apply to office visits but does apply to office-based procedures and surgical services Inpatient: 30% coinsurance	Outpatient: 50% coinsurance Inpatient: 50% coinsurance	Outpatient: 60 visit limit / year. Inpatient: 60 day limit / year (combined with Habilitation services). Services with mental health diagnoses are covered with no limit. Limits are combined with preferred and out-of-network provider networks. Inpatient: Preauthorization required or will not be covered.
	Habilitation services	Outpatient: $60 ($40	Outpatient: 50%	Outpatient: 60 visit limit / year. Inpatient: 60

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)	
		enhanced benefit) / visit Deductible does not apply to office visits but does apply to office-based procedures and surgical services Inpatient: 30% coinsurance	coinsurance Inpatient: 50% coinsurance	day limit / year (combined with Rehabilitation services). Services with mental health diagnoses are covered with no limit. Limits are combined with preferred and out-of-network provider networks. Inpatient: Preauthorization required or will not be covered.
	Skilled nursing care	30% coinsurance	50% coinsurance	60 day limit / year. Limits are combined with preferred and out-of-network provider networks. You must notify Kaiser Permanente of admission or will not be covered.
	Durable medical equipment	30% coinsurance	50% coinsurance	Orthotics covered up to $600 / year. Subject to formulary guidelines. Preauthorization may be required or will not be covered
	Hospice services	30% coinsurance	50% coinsurance	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 Deductible does not apply	No charge Deductible 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.)

- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care (Adult & 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 (20 visit limit / year)
- Hearing aids ($1,000 / 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 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, 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	$1,500
Specialist copayment	$60
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,390**

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

The plan's overall deductible	$1,500
Specialist copayment	$60
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,460**

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

The plan's overall deductible	$1,500
Specialist copayment	$60
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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