**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?** | In-network provider: $200 Individual / $400 Family<br>Shared in and out-of-network | 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?** | In-Network provider: $2,000 Individual / $4,000 Family<br>Shared in and out-of-network | 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 |
|---|---|---|---|---|
| | | In-network 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 | No charge, deductible does not apply. | $10 / visit, deductible does not apply. | None |
| | Specialist visit | $10 / visit, deductible does not apply. | $10 / visit, deductible does not apply. | None |
| | Preventive care/screening/ immunization | No charge, deductible does not apply. | No charge, deductible does not apply. | 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) | No charge, deductible does not apply. | No charge | None |
| | Imaging (CT/PET scans, MRIs) | No charge, deductible does not apply. | No charge | 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/formulary | Preferred generic drugs | $10 (retail); 2x retail cost share (mail order) / prescription, deductible does not apply. | $15 (retail) / prescription, deductible does not apply. | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. |
| | Preferred brand drugs | $10 (retail); 2x retail cost share (mail order) / prescription, deductible does not apply. | $15 (retail) / prescription, deductible does not apply. | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. |
| | Non-preferred drugs | Not covered | $15 (retail) / prescription, deductible does not apply. | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. |
| | Specialty drugs | Applicable Preferred generic or Preferred brand cost shares apply. | Applicable Preferred generic or Preferred brand cost shares apply. | Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $10 / visit, deductible does not apply. | $10 / visit, deductible does not apply. | None |
| | Physician/surgeon fees | No charge | No charge | Physician/surgeon fees are included in the Facility fee. |
| **If you need** | Emergency room care | $75 / visit | $75 / visit | You must notify Kaiser Permanente within 24 |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **immediate medical attention** | | | | 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 | 20% coinsurance, deductible does not apply. | 20% coinsurance, deductible does not apply. | None |
| | Urgent care | No charge, deductible does not apply. | $10 / visit, deductible does not apply. | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | 20% coinsurance | Preauthorization required or will not be covered. |
| | Physician/surgeon fees | No charge | 20% coinsurance | Preauthorization required or will not be covered. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge, deductible does not apply. | $10 / visit, deductible does not apply. | None |
| | Inpatient services | No charge | 20% coinsurance | Preauthorization required or will not be covered. |
| **If you are pregnant** | Office visits | No charge | $10 / visit, deductible does not apply. | Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No charge | 20% 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 | No charge | 20% 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 | No charge, deductible does not apply. | 20% coinsurance | Preauthorization required or will not be covered. |
| | Rehabilitation services | Outpatient: No charge, deductible does not apply. Inpatient: No charge | Outpatient: $10 / visit, deductible does not apply. Inpatient: 20% coinsurance | Combined with Habilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered. Limits are combined with |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | in and out-of-network provider networks. |
| | Habilitation services | Outpatient: No charge, deductible does not apply. Inpatient: No charge | Outpatient: $10 / visit, deductible does not apply. Inpatient: 20% coinsurance | Combined with Rehabilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered. Limits are combined with in and out-of-network provider networks. |
| | Skilled nursing care | No charge | 20% coinsurance | 60-day limit / year. Limits are combined with in and out-of-network provider networks. Preauthorization required or will not be covered. |
| | Durable medical equipment | No charge, deductible does not apply. | No charge | Subject to formulary guidelines. Preauthorization required or will not be covered. |
| | Hospice services | No charge, deductible does not apply. | 20% coinsurance | Preauthorization required or will not be covered. |
| **If your child needs dental or eye care** | Children's eye exam | No charge for refractive exam, deductible does not apply. | $10 / visit, deductible does not apply. | Limited to 1 exam / 12 months |
| | Children's glasses | No charge, deductible does not apply. | Shared with in-network | Members age 19 and over limited to $300 / 12 months; Members under age 19 limited to 1 pair of frames and lenses / year or contract 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.)**

- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care (Adult and child)
- Hearing aids
- 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 (20 visit limit / year)
- Routine eye care (Adult)
- Chiropractic care (20 visit limit / year)
- Infertility treatment ($50,000 medical limit; $35,000 drug limit / lifetime)

**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).
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 | $200 |
| Specialist copayment | $10 |
| Hospital (facility) copayment | $0 |
| Other (blood work) copayment | $0 |

**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 | $200 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$230** |

### 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 | $10 |
| Hospital (facility) copayment | $0 |
| Other (blood work) copayment | $0 |

**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 | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$400** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copayment | $10 |
| Hospital (facility) copayment | $0 |
| Other (x-ray) copayment | $0 |

**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 | $200 |
| Copayments | $100 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$500** |

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