KAISER PERMANENTE® : Flex Silver 94

Coverage for: Individual/Family | Plan Type: HMO

All plans offered and underwritten by Kaiser Foundation Health Plan of Washington

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 1-800-290-8900 (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 1-800-290-8900 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$150 Individual / $300 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 https://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?	$2,250 Individual / $4,500 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-billed charges and health care this plan doesn't cover, 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 1-800-290-8900 (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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	Deductible does not apply to any combination of first 4 primary, specialty, urgent care, or outpatient mental health visits per calendar year.
	Specialist visit	$5 / visit	Not covered	Deductible does not apply to any combination of first 4 primary, specialty, urgent care, or outpatient mental health visits per calendar year.
	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)	5% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRI's)	5% coinsurance	Not covered	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 kp.org/wa/7formulary2023	Preferred generic drugs	Retail: $5 / prescription, deductible does not apply / 30 days; Mail Order: $2 / prescription, deductible does not apply / 30 days	Not covered	Up to 90-day supply (retail & mail order). Subject to formulary guidelines. After the first fill, maintenance drugs are required to be filled at a KFHPWA Clinic or through KFHPWA mail order.
	Preferred brand drugs	Retail: 10% coinsurance / 30 days; Mail Order: 5% coinsurance / 30 days	Not covered	Up to 90-day supply (retail & mail order). Subject to formulary guidelines. After the first fill, maintenance drugs are required to be filled at a KFHPWA Clinic or through KFHPWA mail order.
	Non-Preferred generic/brand drugs	Retail: 40% coinsurance / 30 days; Mail Order: 35% coinsurance / 30 days	Not covered	Up to 90-day supply (retail & mail order). Subject to formulary guidelines. After the first fill, maintenance drugs are required to be filled at a KFHPWA Clinic or through KFHPWA mail order.
	Specialty drugs	40% coinsurance	Not covered	Up to 30-day supply (retail)

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	Not covered	None
	Physician/surgeon fees	5% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	5% coinsurance	5% coinsurance	Must notify Kaiser Permanente within 24 hours if admitted to a Non-network provider; Limited to initial emergency only.
	Emergency medical transportation	5% coinsurance	5% coinsurance	None
	Urgent care	$5 / visit	5% coinsurance	Deductible does not apply to any combination of first 4 primary, specialty, urgent care, or outpatient mental health visits per calendar year. Non-Plan providers covered when temporarily outside the service area: 5% coinsurance
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	Not covered	Preauthorization required or will not be covered.
	Physician/surgeon fee	5% coinsurance	Not covered	Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Deductible does not apply to any combination of first 4 primary, specialty, urgent care, or outpatient mental health visits per calendar year.
	Inpatient services	5% coinsurance	Not covered	Preauthorization required or will not be covered.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you are pregnant	Office visits	No charge, deductible does not apply	Not covered	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 (e.g. ultrasound).
	Childbirth/delivery professional services	5% 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	5% 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	5% coinsurance	Not covered	130 visit limit / year. Preauthorization required or will not be covered.
	Rehabilitation services	Inpatient: 5% coinsurance; Outpatient: $5 / visit	Not covered	Outpatient: 25 visit limit / year. Inpatient: 30 day limit / year. Services with mental health diagnoses are covered with no limit. Preauthorization required for inpatient or will not be covered.
	Habilitation services	Inpatient: 5% coinsurance; Outpatient: $5 / visit	Not covered	Outpatient: 25 visit limit / year. Inpatient: 30 day limit / year. Services with mental health diagnoses are covered with no limit. Preauthorization required for inpatient or will not be covered.
	Skilled nursing care	5% coinsurance	Not covered	60 day limit / year. Preauthorization required or will not be covered.
	Durable medical equipment	5% coinsurance	Not covered	Preauthorization required or will not be covered.
	Hospice service	No charge, deductible does not apply	Not covered	Preauthorization required or will not be covered.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	Not covered	Limited to one exam / 12 months
	Children's glasses	No charge, deductible does not apply	Not covered	Limited to one pair of frames and lenses or contact lenses / year.
	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
- Cosmetic Surgery
- Dental Care (Adult & Child)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care when Traveling Outside the U.S.
- Private-Duty Nursing
- Weight Loss Programs

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

- Abortion
- Acupuncture (12 visits / year)
- Chiropractic Care (10 visits / year)
- Routine Eye Care (Adult & Child)
- Routine Foot Care

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 agency in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-290-8900 (TTY: 711) or https://wa.kaiserpermanente.org/html/public/member-services
Office of the Insurance Commissioner	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? **Not Applicable.**

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 1-800-290-8900 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-290-8900 (TTY: 711)

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-290-8900 (TTY: 711)

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-290-8900 (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** **$150**
- **Specialist copayment** **$5**
- **Hospital (facility) coinsurance** **5%**
- **Other (blood work) coinsurance** **5%**

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	$150
Copayments	$10
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$780**

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

- **The plan's overall deductible** **$150**
- **Specialist copayment** **$5**
- **Hospital (facility) coinsurance** **5%**
- **Other (blood work) coinsurance** **5%**

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	$150
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$550**

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

- **The plan's overall deductible** **$150**
- **Specialist copayment** **$5**
- **Hospital (facility) coinsurance** **5%**
- **Other (x-ray) coinsurance** **5%**

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	$150
Copayments	$30
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$280**

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

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NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (“Kaiser Permanente”) comply with applicable federal civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

- Provide free aids and services to people with disabilities to help ensure effective communication, such as:
  - ☐ Qualified sign language interpreters
  - ☐ Written information in other formats (large print, audio, and accessible electronic formats)
  - ☐ Assistive devices (magnifiers, Pocket Talkers, and other aids)
- Provide free language services to people whose primary language is not English, such as:
  - ☐ Qualified interpreters
  - ☐ Information written in other languages

If you need these services, contact Kaiser Permanente.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance. Please call us if you need help submitting a grievance. The Civil Rights Coordinator will be notified of all grievances related to discrimination. Kaiser Permanente Phone: 206-630-4636, Toll-free: 1-888-901-4636, TTY Washington Relay Service: 1-800-833-6388 or 711, TTY Idaho Relay Service: 1-800-377-3529 or 711. Electronically: kp.org/wa/feedback.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD), Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

HELP IN YOUR LANGUAGE

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

አማርኛ (Amharic) ፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዘዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636رقم هاتف الصم والبكم : (1-800-833-6388 / 711).

中文 (Chinese)：注意：如果您使用繁體中文，您可 以免費獲得語言援助服務。請致電
1-888-901-4636 (TTY: 1-800-833-6388 / 711)。

فارسی (Farsi):توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388/711)تماس بگیرید.

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

日本語 (Japanese): 注意事項：日本語を話される場 合、無料の言語支援をご利用いただけます。1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、 お電話にてご連絡ください。

ភាសាខ្មែរ (Khmer): របយ័តន៖ បើសិនអកនិយែខរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់បំរអក។ ចូរទូ រស័ព 1-888-901-4636 (TTY: 1-800-833-6388 / 711) ។

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍ ລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY: 1-800-833-6388 / 711).