



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 <https://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? | \$1,150 Individual / \$2,300 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? | \$7,900 Individual / \$15,800 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 | \$20 / visit | Not covered | Deductible does not apply to any combination of first 5 primary, specialty, urgent care , or outpatient mental health visits per calendar year. |
| | Specialist visit | \$45 / visit | Not covered | Deductible does not apply to any combination of first 5 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) | 30% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRI's) | 30% 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/7formulary2024 | Preferred generic drugs | Retail: \$10 / prescription , deductible does not apply / 30 days; Mail Order: \$5 / prescription , deductible does not apply / 30 days | Not covered | Up to 90-day supply (retail & mail order). Subject to formulary guidelines. |
| | Preferred brand drugs | Retail: \$40 / prescription , deductible does not apply / 30 days; Mail Order: \$35 / prescription , deductible does not apply / 30 days | Not covered | Up to 90-day supply (retail & mail order). Subject to formulary guidelines. |
| | 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. |
| | 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) | 30% coinsurance | Not covered | None |
| | Physician/surgeon fees | 30% coinsurance | Not covered | None |
| If you need immediate medical attention | Emergency room care | 30% coinsurance | 30% coinsurance | Must notify Kaiser Permanente within 24 hours if admitted to a Non-Plan provider ; limited to initial emergency only. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None |
| | Urgent care | \$45 / visit | 30% coinsurance | Deductible does not apply to any combination of first 5 primary, specialty, urgent care , or outpatient mental health visits per calendar year. Non-Plan providers are not covered inside the service area. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% coinsurance | Not covered | Preauthorization required or will not be covered. |
| | Physician/surgeon fee | 30% coinsurance | Not covered | Preauthorization required or will not be covered. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 / visit | Not covered | Deductible does not apply to any combination of first 5 primary, specialty, urgent care , or outpatient mental health visits per calendar year. |
| | Inpatient services | 30% 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 | 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 | 30% coinsurance | Not covered | 130 visit limit / year. Preauthorization required or will not be covered. |
| | Rehabilitation services | Inpatient: 30% coinsurance ; Outpatient: \$45 / visit | Not covered | Inpatient: 30 day limit / year. Preauthorization required for inpatient or will not be covered. Outpatient: 25 visit limit / year. Services with mental health diagnoses are not subject to visit limits. |
| | Habilitation services | Inpatient: 30% coinsurance ; Outpatient: \$45 / visit | Not covered | Inpatient: 30 day limit / year. Preauthorization required for inpatient or will not be covered. Outpatient: 25 visit limit / year. Services with mental health diagnoses are not subject to visit limits. |
| | Skilled nursing care | 30% coinsurance | Not covered | 60 day limit / year. Preauthorization required or will not be covered. |
| | Durable medical equipment | 30% 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. Inpatient or outpatient respite care limited to a maximum of 14 days per lifetime. |

| 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 .) | | |
|---|---|--|
| <ul style="list-style-type: none"> • Bariatric Surgery • Cosmetic Surgery • Dental Care (Adult & Child) | <ul style="list-style-type: none"> • Hearing Aids • Infertility Treatment • Long-Term Care | <ul style="list-style-type: none"> • 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.) | | |
|--|--|---|
| <ul style="list-style-type: none"> • Abortion • Acupuncture (12 visits / year) | <ul style="list-style-type: none"> • Chiropractic Care (10 visits / year) • Routine Eye Care (Adult) | <ul style="list-style-type: none"> • 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, kwijigo 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) | | Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|-----------------|---|----------------|---|----------------|
| ■ The plan's overall deductible | \$1,150 | ■ The plan's overall deductible | \$1,150 | ■ The plan's overall deductible | \$1,150 |
| ■ Specialist copayment | \$45 | ■ Specialist copayment | \$45 | ■ Specialist copayment | \$45 |
| ■ Hospital (facility) coinsurance | 30% | ■ Hospital (facility) coinsurance | 30% | ■ Hospital (facility) coinsurance | 30% |
| ■ Other (blood work) coinsurance | 30% | ■ Other (blood work) coinsurance | 30% | ■ Other (x-ray) coinsurance | 30% |
| <p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p> | | <p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p> | | <p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p> | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <i>Cost Sharing</i> | | <i>Cost Sharing</i> | | <i>Cost Sharing</i> | |
| Deductibles | \$1,150 | Deductibles | \$1,100 | Deductibles | \$1,150 |
| Copayments | \$10 | Copayments | \$800 | Copayments | \$200 |
| Coinsurance | \$3,100 | Coinsurance | \$0 | Coinsurance | \$300 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$20 | Limits or exclusions | \$0 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$4,280 | The total Joe would pay is | \$1,900 | The total Mia would pay is | \$1,650 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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Notice of Nondiscrimination

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (“Kaiser Permanente”) comply with applicable Federal and Washington state 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 communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, and other 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 Member Services at **1-888-901-4636** (TTY 711).

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 with our Civil Rights Coordinator by writing to P.O. Box 35191, Mail Stop: RCR-A3S-03, Seattle, WA 98124-5191 or calling Member Services at the number listed above. You can file a grievance by mail, phone, or online at kp.org/wa/feedback. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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>
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at **800-562-6900**, **360-586-0241** (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>

Multi-language Interpreter Services

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 711)**.

Español (Spanish): ATENCIÓN: Si habla español, tiene disponibles servicios de ayuda con el idioma sin cargo. Llame al **1-888-901-4636 (TTY 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 711)**。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị nói tiếng Việt, quý vị có thể sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí của chúng tôi. Xin gọi số **1-888-901-4636 (TTY 711)**.

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 제공해 드립니다. **1-888-901-4636 (TTY 711)** 번으로 문의하십시오.

Русский (Russian): ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните по номеру **1-888-901-4636 (TTY 711)**.

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 711)**.

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні послуги перекладу. Телефонуйте за номером **1-888-901-4636 (TTY 711)**.

ភាសាខ្មែរ (Khmer): សូមយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺ មានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **1-888-901-4636 (TTY 711)** ។

日本語 (Japanese): 注意事項: 無料の日本語での言語サポートをご利用いただけます。 **1-888-901-4636 (TTY 711)** まで、お電話にてご連絡ください。

አማርኛ (Amharic): ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አገዛ አገልግሎት፣ በነጻ ለእርስዎ ይቀርባሉ። ወደ **1-888-901-4636 (TTY 711)** ይደውሉ።

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa yoo ta'e, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. **1-888-901-4636 (TTY 711)** irraatti bilbilaa.

ਪੰਜਾਬੀ (Punjabi)ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। **1-888-901-4636 (TTY 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): انتباه إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً اتصل بالرقم **(TTY 711) 1-888-901-4636** م

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

ພາສາລາວ (Lao): ໂປດຂາຍ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ແມ່ນຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທ **1-888-901-4636 (TTY 711)**.