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 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: $600 Individual / $1,200 Family Out-of-Network Provider: None	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?	In Network Provider: $7,500 Individual / $15,000 Family Out-of-Network Provider: No Limit	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?	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	$15 visit, deductible does not apply	$35 visit	Out-of-Network Provider: ~~Limited to certain benefits,~~ Limited to certain benefits up to a combined maximum of 10 services per year.
	Specialist visit	$35 visit, deductible does not apply	$55 visit	Out-of-Network Provider: ~~Limited to certain benefits,~~ Limited to certain benefits up to a combined maximum of 10 services per year.
	Preventive care/screening/ immunization	No charge, deductible does not apply.	No charge	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. Out-of-Network Provider: Limited to certain benefits up to a combined maximum of 10 services per year.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray services $25 visit, deductible does not apply. Lab services: $25 visit, deductible does not apply	X-ray services: $45 visit Lab services: $45 visit	Out-of-Network Provider: Limited to certain benefits up to a combined maximum of 10 services per year.
	Imaging (CT/PET scans, MRIs)	25% 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	$15 (retail); $10 (mail order) / prescription / 30 days, deductible does not apply	$35 (retail) / prescription	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Out-of-Network Provider: Limited to 5 prescription fills up to a 30-day supply per year.
	Preferred brand drugs	$45 (retail) $40 (mail order) / prescription / 30 days, deductible does not apply	$65 (retail) / prescription	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Out-of-Network Provider: Limited to 5 prescription fills up to a 30-day supply per year.
	Non-preferred drugs	40% coinsurance (retail); 35% coinsurance (mail order) / prescription / 30 days	50% coinsurance (retail)	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Out-of-Network Provider: Limited to 5

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)	
				prescription fills up to a 30-day supply per year.
	Specialty drugs	40% coinsurance (retail)	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)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	You must notify Kaiser Permanente within 24 hours if admitted to an Out-of-Network Provider; limited to initial emergency only.
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	$35 visit, deductible does not apply	25% coinsurance	Out-of-Network Providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	Preauthorization required or will not be covered.
	Physician/surgeon fees	25% coinsurance	Not covered	Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 visit, deductible does not apply	$35 visit, deductible does not apply	Out-of-Network Provider: ~~Limited to certain benefits,~~ Limited to certain benefits up to a combined maximum of 10 services per year.
	Inpatient services	25% coinsurance	Not covered	Preauthorization required or will not be covered.
If you are pregnant	Office visits	25% coinsurance	$35 visit, deductible does not apply	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Out-of-Network Provider: Limited to certain benefits up to a combined maximum of 10 services per year.
	Childbirth/delivery professional services	25% 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.

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)	
	Childbirth/delivery facility services	25% 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	25% coinsurance	Not covered	130 visit limit / year. Preauthorization required or will not be covered.
	Rehabilitation services	Outpatient: $35 visit, deductible does not apply Inpatient: 25% coinsurance	Outpatient: $55 / visit Inpatient: Not covered	Outpatient: 25 visit limit / year. Inpatient: 30-day limit / year. Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered. Out-of-Network Provider: Limited to certain benefits up to a combined maximum of 10 services per year.
	Habilitation services	Outpatient: $35 visit, deductible does not apply Inpatient: 25% coinsurance	Outpatient: $55 / visit Inpatient: Not covered	Outpatient:25 visit limit / year. Inpatient: 30-day limit / year. Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered. Out-of-Network Provider: Limited to certain benefits up to a combined maximum of 10 services per year.
	Skilled nursing care	25% coinsurance	Not covered	60-day limit / year. Preauthorization required or will not be covered.
	Durable medical equipment	25% coinsurance	Not covered	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	No charge, deductible does not apply	Not covered	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	No charge for refractive exam	Limited to 1 exam / 12 months. Out-of-Network Provider: Limited to certain benefits up to a combined maximum of 10 services per year.
	Children's glasses	No charge, deductible does not apply.	Not covered	Limited to one pair of frames and lenses or contact lenses / year.

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)	
	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 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 (10 visit limit / year)
- Hearing aids ($2,000 limit / 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/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.

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** **$600**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **25%**
- **Other (blood work) copayment** **$25**

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	$600
Copayments	$200
Coinsurance	$2,600
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,420**

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

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **25%**
- **Other (blood work) copayment** **$25**

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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,100**

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

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **25%**
- **Other (x-ray) copayment** **$25**

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	$600
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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