**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: $2,500 Individual / $5,000 Family<br>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: $8,500 Individual / $17,000 Family<br>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 | $30 / visit, deductible does not apply | $50 / visit | Out-of-Network Provider: Limited to certain benefits up to a combined maximum of 10 services per year. |
| | Specialist visit | $75 / visit, deductible does not apply | $95 / visit | Out-of-Network Provider: 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: $55 / visit, deductible does not apply.<br><br>Lab tests: $55 / visit, deductible does not apply | X-ray services: $75 / visit<br><br>Lab tests: $75 / visit | Out-of-Network Provider: Limited to certain benefits up to a combined maximum of 10 services per year. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not Covered | Preauthorization required or will not be covered. |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at kp.org/wa/7formulary2026 | Preferred generic drugs | $30 (retail);<br>$25 (mail order) / prescription / 30 days, deductible does not apply | $50 (retail); prescription.<br><br>Mail Order: Not covered | 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 | $75 (retail);<br>$70 (mail order) / prescription / 30 days, deductible does not apply | $95 (retail); prescription.<br>Mail Order: Not covered | 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 | 50% coinsurance (retail);<br>45% coinsurance (mail order) / prescription / 30 days | 50% coinsurance (retail); prescription | Up to a 30-day supply (retail); up to 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 |
|---|---|---|---|---|
| | | In Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | Mail Order: Not covered | Out-of-Network Provider: Limited to 5 prescription fills up to a 30-day supply per year. |
| | Specialty drugs | 50% 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) | 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 | You must notify Kaiser Permanente within 24 hours if admitted to an Out-of-Network Provider; limited to initial emergency only. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None |
| | Urgent care | $75 / visit, deductible does not apply | 30% coinsurance | Out-of-Network Provider covered when temporarily outside 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 fees | 30% coinsurance | Not Covered | Preauthorization required or will not be covered. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 / visit, deductible does not apply | $50 / visit | Out-of-Network Provider Limited to certain benefits up to a combined maximum of 10 services per year |
| | Inpatient services | 30% coinsurance | Not Covered | Preauthorization required or will not be covered. |
| **If you are pregnant** | Office visits | 30% coinsurance | $50 / 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 | 30% coinsurance | Not Covered | You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost |

| 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) | |
| | | | | 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 | Outpatient: $65 / visit, deductible does not apply<br>Inpatient: 30% coinsurance | Outpatient: $85 / visit<br>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: $65 / visit, deductible does not apply<br>Inpatient: 30% coinsurance | Outpatient: $85 / visit<br>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 | 30% coinsurance | Not covered | 60-day limit / year. Preauthorization required or will not be covered. |
| | Durable medical equipment | 30% 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 covered | Limited to one pair of frames and lenses or |

| 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) | |
| | | not apply. | | 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 and child)
- Infertility treatment (except for Artificial Insemination)
- 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 the services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Chiropractic care (10 visit limit / year)
- Hearing aids
- 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).
Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-888-901-4636 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4636 (TTY: 711).
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-888-901-4636 (TTY: 711) uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-901-4636 (TTY: 711).
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-901-4636 (TTY: 711).
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 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** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **30%**
- **Other (blood work) copayment** **$55**

**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 | $2,500 |
| Copayments | $300 |
| Coinsurance | $2,600 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is *** | **$5,420** |

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **30%**
- **Other (blood work) copayment** **$55**

**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 | $1,800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,800** |

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **30%**
- **Other (blood work) copayment** **$55**

**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 | $2,000 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,500** |

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

# Nondiscrimination Notice

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them less favorably because of race, color, national origin (including limited English proficiency and primary language), age, disability, sex, sex characteristics (including intersex traits), pregnancy (or related conditions), sex stereotypes, sexual orientation, or gender identity. We also:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, braille, audio, accessible electronic formats, other formats)
- Provide free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 (including limited English proficiency and primary language), age, disability, sex, sex characteristics (including intersex traits), pregnancy (or related conditions), sex stereotypes, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator at P.O. Box 35191, Mail Stop: RCR-A1N-22, Seattle, WA 98124-5191 or by calling **1-888-901-4636** (TTY **711**). You can file a grievance in person or 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.

The notice of nondiscrimination is available at https://healthy.kaiserpermanente.org/washington/language- assistance/nondiscrimination-notice

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**



KAISER PERMANENTE®

# Help in your language

**English: ATTENTION:** If you speak a language other than English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-888-901-4636** (TTY **711**).

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-888-901-4636** (TTY **711**).

**中文 (Chinese) 注意事項：**如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-888-901-4636** (TTY **711**)。

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-888-901-4636** (TTY **711**).

**한국어 (Korean) 주의:** 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-888-901-4636**로 전화해 주세요(TTY **711**).

**Русский (Russian) ВНИМАНИЕ!** Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-888-901-4636** (TTY **711**).

**Tagalog (Tagalog) PAALALA:** Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-888-901-4636** (TTY **711**).

**Українська (Ukrainian) УВАГА!** Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-888-901-4636** (TTY **711**).

**ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖** បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសមស្រប ដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-888-901-4636** (TTY **711**)។

**日本語 (Japanese) 注意：**日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-888-901-4636**までお電話ください(TTY **711**)。

**አማርኛ (Amharic)** ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-888-901-4636** ይደውሉ (TTY **711**)።

**Afaan Oromoo (Oromo) XIYYEEFFANNOO:** Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-888-901-4636** irratti bilbilaa (TTY **711**).

**ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-888-901-4636** (TTY **711**).

**العربية (Arabic)** تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-888-901-4636** (TTY **711**).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-888-901-4636** an (TTY **711**).

**ລາວ (Laotian) ເອົາໃຈໃສ່:** ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-888-901-4636** (TTY **711**).

**International Symbol for ASL (American Sign Language):**

XB0001444-60-25