This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/wa or by calling 1-888-901-4636. The Uniform Glossary can be accessed at: www.cciio.cms.gov

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$300** person/**$600** family; Out-of-network: **$600** person/ **$1,800** family. The deductible does not apply to preventive care by an in-network provider, home health care, hospice, vision and prescriptions.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your **deductible** starts over January 1st. See the chart on page 2 for how much you pay for covered services after you meet the **deductible**. **Note:** If you (and your enrolled spouse) take steps to earn HRA funding during the available time period, your **deductible** may decrease by as much as $500 person/$1,000 family.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 of other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network Medical: **$2,750** person/**$5,500** family Out-of-network Medical: **$5,500** person/**$16,500** family Overall in-network out-of-pocket limit on Essential Health Benefits: **$7,350** person / **$14,500** family	The **out of pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered Medical services. This limit helps you plan for health care expenses. See **Note** above: Medical **out-of-pocket limit** may increase for the same reason as the **deductible** above, by as much as $500 person/$1,000 family due to HRA funding.
What is not included in the out–of–pocket limit?	Co-premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the Medical **out-of-pocket limit**. However, expenses you incur for in-network essential health benefits will count toward the Overall in-network out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services such as of office visits.
Does this plan use a network of providers?	Yes. See www.kp.org/wa or call or call 1-888-901-4636 for a list of in-network-providers.	If you use an in-network doctor, or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participation for **providers** in their **network**. See the chart starting on page 2 for how

Important Questions	Answers	Why this Matters:
		this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. See www.kp.org/wa or call 1-888-901-4636 for a list of specialists providers	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	40% co-insurance	none
	Specialist visit	20% co-insurance	40% co-insurance	none
	Other practitioner office visit	20% co-insurance for manipulative therapy, acupuncture and naturopathy	40% co-insurance for manipulative therapy, acupuncture and naturopathy	Manipulative therapy limited to 10 visits per calendar year combined in and out-of-network, acupuncture limited to 8 visits per medical diagnosis per calendar year combined in and out-of-network, and naturopathy limited to 5 visits per medical diagnosis per calendar year combined in and out-of-network.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No charge	40% co-insurance	Deductible does not apply in-network Services must be listed on the Kaiser well-care schedule.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	none
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/wa or call 1-888-901-4636	Formulary Generic drugs	$6/prescription retail (30-day supply); $18/prescription mail order (90-day supply).		Must use Kaiser pharmacy mail order service only
	Formulary Brand drugs	$22/prescription retail (30-day supply); $66/prescription mail order (90-day supply).		
	Non-formulary Generic/Brand	no coverage		
	Brand Name Drugs with Generic Available	$18/prescription plus the actual difference in cost above generic.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	none
	Physician/surgeon fees	20% co-insurance	40% co-insurance	none
If you need immediate medical attention	Emergency room services	$100/visit plus 20% co-insurance	$100/visit plus 20% co-insurance	Notify Kaiser within 24 hours of admission, or as soon thereafter as medically possible
	Emergency medical transportation	20% co-insurance	20% co-insurance	none
	Urgent care	20% co-insurance	40% co-insurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Preauthorization required for non-emergency inpatient services
	Physician/surgeon fee	20% co-insurance	40% co-insurance	Preauthorization required for non-emergency inpatient services

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	none
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	none
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	none
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Preauthorization required for non-emergency inpatient services.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	Preventive services related to prenatal and preconception care is covered as preventive care. Routine care is not subject to the co-payment.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	Notify Kaiser 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	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization required.
	Rehabilitation services	20% co-insurance	40% co-insurance	Preauthorization required. Limited to 45 visits per calendar year/outpatient. Limited to 30 days per calendar year/inpatient. (combined limit for Rehabilitation and Habilitation services)
	Habilitation services	20% co-insurance	40% co-insurance	
	Skilled nursing care	20% co-insurance	40% co-insurance	Limited to 60 days per calendar year combined in and out-of-network. Requires preauthorization.
	Durable medical equipment	20% co-insurance	40% co-insurance	none
	Hospice service	No charge	No charge	Preauthorization required.
If your child needs dental or eye care	Eye exam	20% co-insurance	40% co-insurance	Limited to one exam every 12 months Benefit does not start until the participant has been employed by the group for 12 months.
	Glasses	Charges over $150	Charges over $150	Limited to $150 every 12 months. Benefit does not start until the participant has been employed by the group for 12 months.
	Dental check-up	See dental plan	See dental plan	Dental benefits can vary depending on plan choice.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long Term Care
- Most coverage provided outside the United States. See www.kp.org/wa
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care (if prescribed for rehabilitation purposes)
- Hearing aids
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-225-7620. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S.. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Kaiser Permanente at 1-888-901-4636 or the Department of Labor' Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-901-4636.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,630
- **Patient pays** $1,910

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$600
Co-pays	$10
Co-insurance	$1,100
Limits or exclusions	$200
Total	**$1,910**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,540
- **Patient pays** $860

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Co-pays	$400
Co-insurance	$80
Limits or exclusions	$80
Total	**$860**

Note: These numbers assume the patient has completed HRA funding requirements listed on page 1 and earned credit of $500.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.