
 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, visit [www.kp.org/wa](http://www.kp.org/wa) or call 1-888-901-4636. 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.kp.org/wa](http://www.kp.org/wa) or call 1-888-901-4636 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>Preferred providers: <b>\$300</b> person/<b>\$600</b> family.                      Non-preferred providers: <b>\$600</b> person/<b>\$1,800</b> family</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.  <b>Note:</b> If you (and your enrolled spouse) fail to take steps to earn maximum HRA funding during the available time period, your <u>deductible</u> may be increased by as much as \$500 person/\$1,000 family.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. <u>Preventive care</u> by a <u>preferred provider</u>, <u>home health care</u>, <u>hospice services</u>, vision and <u>prescription drugs</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">http://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>In-network Medical: <b>\$2,750</b> person/<b>\$5,500</b> family                      Out-of-network Medical: <b>\$5,500</b> person/<b>\$16,500</b> family                      Overall in-network <u>out-of-pocket limit</u> on Essential Health Benefits: <b>\$9,100</b> person / <b>\$18,200</b> family</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                      See <b>Note</b> above: Medical <u>out-of-pocket limit</u> may increase for the same reasons as the <u>deductible</u> above, by as much as \$500 person/\$1,000 family due to unearned HRA funding.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Emergency room copays, <u>premiums</u>, <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the Medical <u>out-of-pocket limit</u>. However, expenses you incur for in-network essential health benefits will count toward the overall in-network <u>out-of-pocket limit</u> on Essential Health Benefits.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See <a href="http://www.kp.org/wa">www.kp.org/wa</a> or call or call 1-888-901-4636 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services</p>

		(such as lab work). Check with your <u>provider</u> before you get services
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	<u>Deductible</u> does not apply in-network. Services must be listed on the Kaiser well care schedule, which can be found at <a href="https://wa.kaiserpermanente.org/html/public/member-guide/well-care">https://wa.kaiserpermanente.org/html/public/member-guide/well-care</a> . You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.kp.org/wa">www.kp.org/wa</a> or call 1-888-901-4636.	<u>Formulary</u> Generic drugs	\$6/prescription retail (30-day supply); \$18/prescription mail order (90-day supply).		Must use Kaiser pharmacy mail order service only
	<u>Formulary</u> Brand drugs	\$22/prescription retail (30-day supply); \$66/prescription mail order (90-day supply).		
	<u>Non-formulary</u> Generic/Brand	No coverage		
	Brand Name Drug 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% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100/visit plus 20% <u>coinsurance</u>	\$100/visit plus 20% <u>coinsurance</u>	Notify Kaiser within 24 hours of admission, or as soon thereafter as medically possible

\* For more information about limitations and exceptions, see the plan or policy document at [www.soundhealthwellness.com](http://www.soundhealthwellness.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for non-emergency inpatient services
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for non-emergency inpatient services
<b>If you need mental health, behavioral health, or substance abuse services</b>	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Substance abuse disorder outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Substance abuse disorder inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for non-emergency inpatient services.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits for employee or spouse only. <u>Cost sharing</u> does not apply for <u>preventive services</u> by a <u>network provider</u> . Depending on the type of services, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits for employee or spouse only. Newborn services cost shares are separate from that of the mother.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits for employee or spouse only. 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.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	No charge	<u>Preauthorization</u> required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required if community provider used. Limited to 45 visits per calendar year/outpatient. Limited to 30 days per condition per calendar year/inpatient.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

\* For more information about limitations and exceptions, see the plan or policy document at [www.soundhealthwellness.com](http://www.soundhealthwellness.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				(Combined limit for <u>Rehabilitation services</u> and <u>Habilitation services</u> )
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days per calendar year combined in and out-of-network. Requires <u>preauthorization</u> .
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge	No charge	<u>Preauthorization</u> required
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to one exam every 12 months. Benefit does not start until the participant has been employed by the group for 12 months.
	Children's 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.
	Children's dental check-up	See dental plan	See dental plan	Dental benefits vary depending on plan choice.

#### 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.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long Term Care
- Most coverage provided outside the United States. See [www.kp.org/wa](http://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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care (if prescribed for rehabilitation purposes)
- 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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). You may also contact the Washington State Office of the Insurance Commissioner at 1-800-562-6900.

**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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$10
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,810</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$400
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,020</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ <u>The plan's overall deductible</u>	\$300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$100
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>