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 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 or call 1-888-901-4636 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred providers: **$250** person/**$500** family. Non-preferred providers: **$500** person/**$1,000** 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 policy, the overall family deductible must be met before the plan begins to pay. **Note:** If you (and your enrolled spouse) fail to take steps to earn maximum HRA funding during the available time period, your deductible may be increased by as much as $500 person/$1,000 family.
Are there services covered before you meet your deductible?	Yes. Preventive care by a preferred provider, home health care, hospice services, vision and prescription drugs.	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 http://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 Medical: **$2,250** person/**$4,500** family Out-of-network Medical: **$4,500** person/**$9,000** family Overall in-network out-of-pocket limit on Essential Health Benefits: **$7,350** person / **$14,700** family	The Medical 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. See **Note** above: Medical out-of-pocket limit may increase for the same reasons as the deductible above, by as much as $500 person/$1,000 family due to unearned HRA funding.
What is not included in the out-of-pocket limit?	Emergency room copays, premiums, balance billing 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 on Essential Health Benefits.
Will you pay less if you use a network provider?	Yes. See www.kp.org/wa or call or call 1-888-901-4636 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.	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
		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% coinsurance	40% coinsurance	None
	Specialist visit	15% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	Deductible does not apply in-network. Services must be listed on the Kaiser well care schedule, which can be found at https://wa.kaiserpermanente.org/html/public/member-guide/well-care. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	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	$35/prescription retail (30-day supply); $70/prescription mail order (90-day supply)		
	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)	15% coinsurance	40% coinsurance	None
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at 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)	
If you need immediate medical attention	Emergency room care	$100/visit plus 15% coinsurance	$100/visit plus 15% coinsurance	Notify Kaiser within 24 hours of admission, or as soon thereafter as medically possible
	Emergency medical transportation	15% coinsurance	15% coinsurance	None
	Urgent care	15% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Preauthorization required for non-emergency inpatient services.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	Preauthorization required for non-emergency inpatient services.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	15% coinsurance	40% coinsurance	None
	Mental/Behavioral health inpatient services	15% coinsurance	40% coinsurance	None
	Substance abuse disorder outpatient services	15% coinsurance	40% coinsurance	None
	Substance abuse disorder inpatient services	15% coinsurance	40% coinsurance	Preauthorization required for non-emergency inpatient services.
If you are pregnant	Office visits	15% coinsurance	40% coinsurance	Benefits for employee or spouse only. Cost sharing does not apply for preventive services by a network provider. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	Benefits for employee or spouse only. Newborn services cost shares are separate from that of the mother.
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	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.
If you need help recovering or have other special health	Home health care	No charge	No charge	Preauthorization required.
	Rehabilitation services	15% coinsurance	40% coinsurance	Preauthorization required. Limited to 45 visits per calendar year/outpatient. Limited to 30
	Habilitation services	15% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at 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)	
needs				days per calendar year/inpatient. (Combined limit for Rehabilitation services and Habilitation services)
	Skilled nursing care	15% coinsurance	40% coinsurance	Preauthorization required. Limited to 60 days per calendar year.
	Durable medical equipment	15% coinsurance	40% coinsurance	None
	Hospice services	No charge	No charge	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	15% coinsurance	40% coinsurance	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
- 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)

* For more information about limitations and exceptions, see the plan or policy document at www.soundhealthwellness.com.

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. 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 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. 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**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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, kwiijigo holne' [insert telephone number].]

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

* For more information about limitations and exceptions, see the plan or policy document at www.soundhealthwellness.com.

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)

■ The plan's overall deductible	$250
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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	$250
Copayments	$20
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,130**

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

■ The plan's overall deductible	$250
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,110**

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

■ The plan's overall deductible	$250
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**