

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**

**Coverage Period: Beginning on or after 01/01/2019**

**KAISER PERMANENTE: NW \$2,850 Deductible Plan with HSA**

**Coverage for: Individual / Family | Plan Type: HDHP**

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest



**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](http://www.kp.org/plandocuments) or call 1-877-580-6125 (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 <http://www.healthcare.gov/sbc-glossary> or call 1-877-580-6125 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$2,850</b> Individual / <b>\$5,700</b> Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<b>Yes.</b> <u>Preventive care</u> and services indicated in chart starting on page 2.	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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>No.</b>	You don't have to meet deductibles for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <u>plan</u>?</b>	<b>\$6,550</b> Individual / <b>\$13,100</b> Family	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	<b>Yes.</b> See <a href="http://www.kp.org/mercermarketplace">www.kp.org/mercermarketplace</a> or call 1-877-580-6125 (TTY: 711) for a list of <u>select providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network providers</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	<b>Yes</b> , but you may self-refer to certain <u>specialists</u> .	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
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	30% <u>coinsurance</u>	Not covered	None
	<a href="#">Specialist</a> visit	30% <u>coinsurance</u>	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge, <u>deductible</u> does not apply.	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: 30% <u>coinsurance</u> Lab tests: 30% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Not covered	Some services may require prior authorization
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs	30% <u>coinsurance</u> (retail & mail order)	Not covered	Up to a 30-day supply (retail) or 90-day supply (mail order). Subject to <u>formulary</u> guidelines.
	Preferred brand drugs	30% <u>coinsurance</u> (retail & mail order)	Not covered	Up to a 30-day supply (retail) or 90-day supply (mail order). Subject to <u>formulary</u> guidelines.
	Non-preferred brand drugs	30% <u>coinsurance</u> (retail & mail order)	Not covered	Up to a 30-day supply (retail) or 90-day supply (mail order). Subject to <u>formulary</u> guidelines, when approved through exception process.
	<a href="#">Specialty drugs</a>	Applicable Generic, Preferred brand, Non-preferred brand drugs <u>cost shares</u> apply.	Not covered	Up to a 30-day supply (retail). Subject to <u>formulary</u> guidelines, when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	Prior authorization required.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<a href="#">Emergency medical transportation</a>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<a href="#">Urgent care</a>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Non-participating providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	Prior authorization required.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	Not covered	None
	Inpatient services	30% <u>coinsurance</u>	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge, <u>deductible</u> does not apply.	Not covered	Depending on the type of services, a <u>copayment</u> , <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	30% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not covered	Prior authorization required.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <u>coinsurance</u>	Not covered	120 visit limit / year. Prior authorization required.
	<a href="#">Rehabilitation services</a>	Outpatient: 30% <u>coinsurance</u> Inpatient: 30% <u>coinsurance</u>	Not covered	Inpatient: Prior authorization required
	<a href="#">Habilitation services</a>	Outpatient: 30% <u>coinsurance</u> Inpatient: 30% <u>coinsurance</u>	Not covered	Inpatient: Prior authorization required
	<a href="#">Skilled nursing care</a>	30% <u>coinsurance</u>	Not covered	120 day limit / year. Prior authorization required.
	<a href="#">Durable medical equipment</a>	30% <u>coinsurance</u>	Not covered	Subject to <u>formulary</u> guidelines. Prior authorization required.
	<a href="#">Hospice services</a>	30% <u>coinsurance</u>	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Children's glasses</li> <li>Cosmetic surgery</li> <li>Dental care (Adult and child)</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult and child)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
<ul style="list-style-type: none"> <li>Acupuncture (30 visit limit / year)</li> <li>Bariatric surgery</li> <li>Chiropractic care (30 visit limit / year)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (Adults: \$1,000 limit / ear / 36 months; under age 18: 1 aid / ear / 36 months)</li> </ul>

**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](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 agencies in the chart below.

**Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:**

Kaiser Permanente Member Services	1-800-813-2000 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a> .
Oregon Department of Insurance	1-888-877-4894 or <a href="http://www.dfr.oregon.gov">www.dfr.oregon.gov</a>
Washington Department of Insurance	1-800-562-6900 or <a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a>

### 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 Standard](#), 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 1-800-813-2000 (TTY: 711).

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711).

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-813-2000 (TTY: 711).

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-813-2000 (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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,850
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other (blood work) <a href="#">coinsurance</a>	30%

#### 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>\$12,800</b>
---------------------------	-----------------

#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,850
Copayments	\$0
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,110</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,850
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other (blood work) <a href="#">coinsurance</a>	30%

#### 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>\$7,400</b>
---------------------------	----------------

#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,850
Copayments	\$0
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$4,110</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,850
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other (x-ray) <a href="#">coinsurance</a>	30%

#### 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>\$1,900</b>
---------------------------	----------------

#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

