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.** Please read the FEHB Plan brochure (RI 73-012) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds/wa-core, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-888-901-4636 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	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?	$3,000 / person up to $6,000 / family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be 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 1-888-4636 (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. See www.kp.org/wa or call 1-888-901-4636 (TTY: 711) for a list of specialist providers.	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, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 / visit	Not covered	None
	Specialist visit	$25 / visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	Services must be in accordance with the Kaiser Permanente well-care schedule. 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)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Preauthorization required or will not be covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/wa	Formulary generic drugs	$20 (retail); $40 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Formulary brand drugs	$40 (retail); $80 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Non-formulary drugs	$60 (retail); $120 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Specialty drugs	Preferred: 25% coinsurance up to $200 (retail) / prescription Non-preferred: 50% coinsurance up to $500 (retail) / prescription	Not covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 / visit	Not covered	None

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, plus you may be balance billed)	
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	You must notify Kaiser Permanente within 24 hours if admitted to a Non-network provider; limited to initial emergency only. Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$25 / visit	$100 / visit	Non-Network providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 / admission	Not covered	Preauthorization required or will not be covered.
	Physician/surgeon fees	Included in facility fee	Not covered	Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit Nothing for group therapy	Not covered	None
	Inpatient services	$350 / admission	Not covered	Preauthorization required or will not be covered.
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Included in facility fee	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.
	Childbirth/delivery facility services	$350 / admission	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as

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, plus you may be balance billed)	
				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	No charge	Not covered	Preauthorization required or will not be covered.
	Rehabilitation services	Outpatient: $25 / visit Inpatient: $350 / admission	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with Habilitation services). Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered.
	Habilitation services	Outpatient: $25 / visit Inpatient: $350 / admission	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with Rehabilitation services). Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered.
	Skilled nursing care	No charge	Not covered	100-day limit / year. Preauthorization required or will not be covered.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	No charge	Not covered	Preauthorization required or will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 exam / 12 months up to age 17.
	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 Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental Care (Adult and child)
- Hearing aids
- Long-term care
- Private duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
• Acupuncture (8 visit limits / year) • Bariatric surgery • Chiropractic care (20 visit limits / year)	• Infertility treatment • Non-emergency care when traveling outside the U.S. See FEHB Plan Brochure for information	• Routine eye care • Routine foot care

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at (RI 73-012)or visit www.opm.gov/healthcare-insurance/healthcare. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: Kaiser Foundation Health Plan of Washington Member Appeal Department at 1-866-458-5479

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.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-901-4636.Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4636.

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** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$350**
- **Other (blood work) copayment** **$0**

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	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$420**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$350**
- **Other (blood work) copayment** **$0**

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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,100**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$350**
- **Other (x-ray) copayment** **$0**

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	$0
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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

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.** Please read the FEHB Plan brochure (RI 73-012) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds/wa-core, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-888-901-4636 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	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?	$5,000 per person or per family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be 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 1-888-4636 (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. See www.kp.org/wa or call 1-888-901-4636 (TTY: 711) for a list of specialist providers.	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, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 / visit	Not covered	No primary care copayment for children through age 17.
	Specialist visit	$35 / visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	Services must be in accordance with the Kaiser Permanente well-care schedule. 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)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 / visit	Not covered	Preauthorization required or will not be covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/wa	Formulary generic drugs	Preventive: $5 (retail); $10 (mail order) / prescription. $20 (retail); $40 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Formulary brand drugs	$40 (retail); $80 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Non-formulary drugs	$60 (retail); $120 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Specialty drugs	Preferred: 25% coinsurance up to $200 (retail) / prescription Non-preferred: 50% coinsurance up to $500 (retail) / prescription	Not covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / visit	Not covered	None

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, plus you may be balance billed)	
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	$150 / visit	$150 / visit	You must notify Kaiser Permanente within 24 hours if admitted to a Non-network provider; limited to initial emergency only. Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	$100 / trip	$100 / trip	None
	Urgent care	$25 / primary care visit; $35 / specialty care visit	$150 / visit	Non-Network providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 / admission	Not covered	Preauthorization required or will not be covered.
	Physician/surgeon fees	Included in facility fee	Not covered	Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit; Nothing for group therapy	Not covered	None
	Inpatient services	$750 / admission	Not covered	Preauthorization required or will not be covered.
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Included in facility fee	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.
	Childbirth/delivery facility services	$750 / admission	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.

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, plus you may be balance billed)	
If you need help recovering or have other special health needs	Home health care	$25 / visit	Not covered	Preauthorization required or will not be covered.
	Rehabilitation services	Outpatient: $25 / primary care visit; $35 / specialty care visit Inpatient: $750 / admission	Not covered	No primary care copayment for children through age 17. Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with Habilitation services). Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered.
	Habilitation services	Outpatient: $25 / primary care visit; $35 / specialty care visit Inpatient: $750 / admission	Not covered	No primary care copayment for children through age 17. Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with Rehabilitation services). Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered.
	Skilled nursing care	No charge	Not covered	100-day limit / year. Preauthorization required or will not be covered.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	No charge	Not covered	Preauthorization required or will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 exam / 12 months up to age 17.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental Care (Adult and child)
- Hearing aids
- Long-term care
- Private duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Acupuncture (8 visit limit / year)
- Bariatric surgery
- Chiropractic care (20 visit limit / year)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See the FEHB Plan Brochure for information
- Routine eye care
- Routine foot care

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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:

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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-901-4636

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4636

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	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$750**
Other (blood work) copayment	**$0**

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	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$820**

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

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$750**
Other (blood work) copayment	**$0**

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	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$750**
Other (x-ray) copayment	**$0**

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	$0
Copayments	$400
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$460**

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

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.** Please read the FEHB Plan brochure (RI 73-012) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds/wa-core, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-888-901-4636 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 / person up to $500 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. 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?	$6,000 / person up to $12,000 / family	The out-of-pocket limit, or catastrophic maximum, 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. See www.kp.org/wa or call 1-888-901-4636 (TTY: 711) for a list of specialist providers.	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, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	Not covered	Deductible applies to procedures received during an office visit.
	Specialist visit	$40 / visit	Not covered	Deductible applies to procedures received during an office visit.
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	Services must be in accordance with the Kaiser Permanente well-care schedule. 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)	Lab services: No charge X-ray services: $50 / visit; deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$150 / visit; deductible does not apply	Not covered	Preauthorization required or will not be covered.

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, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/wa	Formulary generic drugs	Preventive: $5 (retail); $10 (mail order) / prescription $20 (retail); $40 (mail order) / prescription; deductible does not apply	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Formulary brand drugs	$60 (retail); $120 (mail order) / prescription; deductible does not apply	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Non-formulary drugs	$100 (retail); $200 (mail order) / prescription; deductible does not apply	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Specialty drugs	Preferred: 35% coinsurance up to $300 (retail) / prescription Non-preferred: 50% coinsurance up to $500 (retail) / prescription; deductible does not apply	Not covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / visit	Not covered	None
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	$200 / visit	$200 / visit	You must notify Kaiser Permanente within 24 hours if admitted to a Non-network provider; limited to initial emergency only. Copayment waived if admitted directly to the hospital as an inpatient.

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, plus you may be balance billed)	
	Emergency medical transportation	20% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	None
	Urgent care	$15 / primary care visit; $40 / specialty care visit; deductible does not apply	$15 / primary care visit; $40 / specialty care visit; deductible does not apply	Non-Network providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 / day up to $1,050 / admit	Not covered	Preauthorization required or will not be covered.
	Physician/surgeon fees	Included in facility fee	Not covered	Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 / visit Nothing for group therapy; deductible does not apply	Not covered	None
	Inpatient services	$350 / day up to $1,050 / admit	Not covered	Preauthorization required or will not be covered.
If you are pregnant	Office visits	No charge, deductible does not apply	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Included in facility fee	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.
	Childbirth/delivery facility services	$350 / day up to $1,050 / admit	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	Home health care	$15 / visit	Not covered	Preauthorization required or will not be covered.

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, plus you may be balance billed)	
other special health needs	Rehabilitation services	Outpatient: $15 / Primary care visit; $40 / specialty care visit Inpatient: $350 / day up to $1,050 / admit	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with Habilitation services). Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered.
	Habilitation services	Outpatient: $15 / Primary care visit; $40 / specialty care visit Inpatient: $350 / day up to $1,050 / admit	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with Rehabilitation services). Services with mental health diagnoses are covered with no limit. Inpatient: Preauthorization required or will not be covered.
	Skilled nursing care	Nothing after deductible	Not covered	100-day limit / year. Preauthorization required or will not be covered.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	No charge	Not covered	Preauthorization required or will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 exam / 12 months
	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 Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult and child)
- Hearing aids
- Long-term care
- Private duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Acupuncture (8 visit limit / year)
- Bariatric surgery
- Chiropractic care (20 visit limit / year)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See FEHB Plan Brochure for information
- Routine eye care
- Routine foot care

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at (RI 73-012)or visit www.opm.gov/healthcare-insurance/healthcare. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: Kaiser Foundation Health Plan of Washington Member Appeal Department at 1-866-458-5479

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.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-901-4636.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4636.

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	**$250**
Specialist copayment	**$40**
Hospital (facility) copayment	**$350**
Other (blood work) **copayment**	**$0**

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 Sharing500	
Deductibles	$250
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$770**

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 copayment	**$40**
Hospital (facility) copayment	**$350**
Other (blood work) **copayment**	**$0**

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	$250
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,650**

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

The plan's overall deductible	**$250**
Specialist copayment	**$40**
Hospital (facility) copayment	**$350**
Other (x-ray) **copayment**	**$50**

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	$250
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

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