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 73-051) 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 view the FEHB Plan brochure and the Glossary at www.kp.org/feds/wa-options. You can 1-888-901-4636 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$350** / person up to **$700** / 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?	**$5,000** / person **$10,000** / family* Non-Plan providers: Unlimited	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. *($5,000 per person; not to exceed a total out-of-pocket limit of $10,000)
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	$25 / visit, deductible does not apply	$25 / visit, then 40% coinsurance, deductible does not apply	Copay applies only to the office visit; deductible and/or applicable coinsurance will apply to all other services ordered during the visit (e.g., lab and/or x-ray, surgical procedures).
	Specialist visit	$35 / visit, deductible does not apply	$35 / visit, then 40% coinsurance, deductible does not apply	
	Preventive care/screening/ immunization	No charge, deductible does not apply	40% coinsurance, deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	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/fehb-options	Tier 1 Generic drugs	$20 (retail); $40 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Tier 2 Preferred brand drugs	$40 (retail); $80 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Tier 3 Non-preferred drugs	$60 (retail); $120 (mail order) / prescription	Not covered	Up to a 30-day supply. Must be ordered by physician with preauthorization.
	Tier 4 Preferred specialty drugs Tier 5 Non-preferred specialty drugs	Preferred: 25% coinsurance up to $200 (retail) / prescription	Not covered	Up to a 30-day supply. Must be ordered by physician with preauthorization.

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)	
		Non-preferred: 35% coinsurance up to $300 (retail) / prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	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	20% coinsurance	20% coinsurance	None
	Urgent care	$25 / Primary care visit, deductible does not apply $35 / Specialist care visit, deductible does not apply	$25 / Primary care visit, deductible does not apply $35 / Specialist care visit, deductible does not apply	Copay applies only to the office visit; deductible and/or applicable coinsurance will apply to all other services ordered during the visit (e.g., lab and/or x-ray, surgical procedures). Non-Network providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	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 mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit, deductible does not apply	$25 / visit, then 40% coinsurance, deductible does not apply	Copay applies only to the office visit; deductible and/or applicable coinsurance will apply to all other services ordered during the visit (e.g., lab and/or x-ray, surgical procedures).
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
If you are pregnant	Office visits	No charge, deductible does not apply	40% coinsurance, deductible does not apply	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	No charge, deductible does not apply	40% coinsurance, deductible does not apply	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	No charge, deductible does not apply	40% coinsurance, deductible does not apply	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 other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
	Rehabilitation services	Outpatient: $25 / Primary care visit, deductible does not apply $35 / Specialist care visit, deductible does not apply Inpatient: 20% coinsurance	$25 / Primary care visit, then 40% coinsurance, deductible does not apply $35 / Specialist care visit, then 40% coinsurance, deductible does not apply Inpatient: 40% coinsurance	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.

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)	
	Habilitation services	$25 / Primary care visit, deductible does not apply $35 / Specialist care visit, deductible does not apply Inpatient: 20% coinsurance	$25 / Primary care visit, then 40% coinsurance, deductible does not apply $35 / Specialist care visit, then 40% coinsurance, deductible does not apply Inpatient: 40% coinsurance	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	20% coinsurance	40% coinsurance	60-day limit / year. Preauthorization required or will not be covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	40% coinsurance, deductible does not apply	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)
- Long-term care
- Non-emergency care received in an emergency room
- Non-urgently needed care received in an urgent care clinic
- 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 (20 visit limit / year)
- Bariatric
- Hearing aids
- Infertility treatment
- Routine eye care
- Routine foot care

- Chiropractic (20 visit limit / year)
- Non-emergency care when traveling outside the U.S. See FEHB Brochure for information

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 73-051)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 Permanente Washington Options Federal 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** **$350**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other** (blood work) **coinsurance** **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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$10
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$410**

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

- **The plan's overall deductible** **$350**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other** (blood work) **coinsurance** **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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$1,100
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,460**

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

- **The plan's overall deductible** **$350**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other** (x-ray) **coinsurance** **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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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 73-051) 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?	**$1,500** / person up to **$3,000** / 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?	**$5,000** / person up to **$10,000** / 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. *($5,000 per person not to exceed a total out-of-pocket limit of $10,000; each applies separately for services received from Plan providers and non-Plan providers).
What is not included in the out-of-pocket limit?	Premiums, deductible, copayments on certain services, balance-billing charges, and 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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	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/fehb-options.com	Tier 1 Generic drugs	$20 (retail); $40 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Tier 2 Preferred brand drugs	$40 (retail); $80 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Tier 2 Non-preferred drugs	$60 (retail); $120 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Tier 4 Preferred specialty drugs	Preferred: 25% coinsurance up to $200 (retail) / prescription	Not covered	Up to a 30-day supply. Must be ordered by physician with preauthorization.

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)	
	Tier 5 Non-preferred specialty drugs	Non-preferred: 35% coinsurance up to $300 (retail) / prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	You must notify Kaiser Permanente within 24 hours if admitted to a Non-network provider; limited to initial emergency only.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	Non-Network providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	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	20% coinsurance	40% coinsurance	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	20% coinsurance	40% coinsurance	Preauthorization required or will not be covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	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	20% coinsurance	40% coinsurance	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	20% coinsurance	40% coinsurance	60-day limit / year. Preauthorization required or will not be covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	20% coinsurance	40% coinsurance	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
- Long-term care
- Dental care (Adult and child)
- Non-emergency care received in an emergency room
- Non-urgently needed care received in an urgent care clinic
- 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 (20 visit limit / year)
- Hearing Aids
- Routine eye care

- 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 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 73-051) 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** **$1,500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other (blood work) coinsurance** **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,530**

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

- **The plan's overall deductible** **$1,500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other (blood work) coinsurance** **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,400**

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

- **The plan's overall deductible** **$1,500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other (x-ray) coinsurance** **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,810**

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

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable federal civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

Provide free aids and services to people with disabilities to help ensure effective communication, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats)
- Assistive devices (magnifiers, Pocket Talkers, and other aids)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance. Please call us if you need help submitting a grievance. The Civil Rights Coordinator will be notified of all grievances related to discrimination.

Kaiser Permanente
Phone: 206-630-4636
Toll-free: 1-888-901-4636
TTY Washington Relay Service: 1-800-833-6388 or 711
TTY Idaho Relay Service: 1-800-377-3529 or 711
Electronically: kp.org/wa/feedback

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可 以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY: 1-800-833-6388 / 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ **(Khmer)**៖ របយ័ត៖ បើសិនអកនិយែខរ, សេជំនួយែផក យេមិនគិតល គឺចនសំប់ប់ំរអក។ ចូរទូ រស័ព 1-888-901-4636 (TTY: 1-800-833-6388 / 711)។

日本語 (Japanese): 注意事項： 日本語を話される場 合、無料の言語支援をご利用いただけます。1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、 お電話にてご連絡ください。

አማርኛ (Amharic) ፥ ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ **(Punjabi)** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 رقم هاتف الصم والبكم: (1-800-833-6388 / 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍ ລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 1-800-833-6388 / 711) 1-888-901-4636 تماس بگیرید.

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