



## Summary of Benefits and Coverage (SBC)

The Annual Enrollment period for Medical Plan enrollment is **November 1 – December 15**. During this period, you have the option to select the Medical PPO Plan (using the Premera PPO network) or the Kaiser Permanente of Washington Plan if you live in a Kaiser service area. When you are ready to complete Annual Enrollment, **Login** to [www.nwadmin.com](http://www.nwadmin.com) and select **Annual Enrollment** on the left side of the page.

This document contains both the Medical PPO SBC and Kaiser SBC. **If you do not live in a Kaiser service area, please disregard the Kaiser SBC**, you will be defaulted into the Medical PPO Plan. See below link to the Kaiser service area zip code listing to check if you are in the Kaiser service area. If you wish to change plans and miss the December 15 deadline, you will not be able to change medical plans until Annual Enrollment the fall of next year, but you must still re-enroll for medical coverage to avoid any delays on medical claim processing. Click below, to link to the Washington Teamsters Welfare Trust SBCs and Kaiser Service area zip code listing:

[SBC – Medical PPO Plan \(using the Premera PPO network\)](#)


[SBC – Kaiser Permanente of Washington Medical Plan Option](#)

[Kaiser Service Area Zip Code List](#)



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.wateamsters.com](http://www.wateamsters.com) or call 1-800-458-3053. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-458-3053 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 individual / \$0 family	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 per family for durable medical equipment and supplies. \$25 per visit to ER in a non-PPO hospital.	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For medical benefits it is \$500 per family. Goes to \$400 if you complete the Health Assessment, \$600 if you do not.	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, deductibles, co-pays, non-covered charges, prescriptions, and obesity care.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.wateamsters.com">www.wateamsters.com</a> and select Premera BlueCard Network Directory or call 1-800-810-2583 for a list of participating providers. Be sure to reference the alpha prefix TMP. For prescription drugs see <a href="http://www.medimpact.com">www.medimpact.com</a> or call 1-800-788-2949.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	10% co-insurance	10% co-insurance	Applies to charge for the office visit only not other professional fees.
	<a href="#">Specialist</a> visit	10% co-insurance	10% co-insurance	Applies to charge for the office visit only not other professional fees.
	<a href="#">Preventive care/screening/immunization</a>	No charge	10% co-insurance	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% co-insurance	10% co-insurance	None
	Imaging (CT/PET scans, MRIs)	10% co-insurance	10% co-insurance	None
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.medimpact.com">www.medimpact.com</a>	Generic drugs	Retail: 0% or 10% co-pay/prescription; Mail order: 0%	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	Preferred brand drugs	Retail: 10% or 20% co-pay/prescription; Mail order: \$20 co-pay/prescription	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	Non-preferred brand drugs	Retail: 10% or 20% co-pay/prescription; Mail order: \$20 co-pay/prescription	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	<a href="#">Specialty drugs</a>	Mail Order only: \$20 co-pay/prescription	Not covered except for a medical emergency	Mail Order only. Covers up to 100-day supply for mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% co-insurance	None
	Physician/surgeon fees	10% co-insurance	10% co-insurance	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	\$25 on first \$2,025 charges then 10% co-insurance	Notify Plan within 24 hours of admission
	<a href="#">Emergency medical transportation</a>	10% co-insurance	10% co-insurance	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)	
	<a href="#">Urgent care</a>	10% co-insurance	10% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$0 on first \$2,000 charges then 10% co-insurance	Prior Authorization Required
	Physician/surgeon fees	10% co-insurance	10% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% co-insurance	10% co-insurance	None
	Inpatient services	No charge	\$0 on first \$2,000 charges then 10% co-insurance	Prior Authorization Required
If you are pregnant	Office visits	10% co-insurance	10% co-insurance	None
	Childbirth/delivery professional services	10% co-insurance	10% co-insurance	Prior Authorization Required. Newborn cost sharing is separate from that of the mother.
	Childbirth/delivery facility services	No charge	\$0 on first \$2,000 charges then 10% co-insurance	Prior Authorization Required. Newborn cost sharing is separate from that of the mother.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	\$0 on first \$2,000 charges then 10% co-insurance	Limited to 130 visits per year
	<a href="#">Rehabilitation services</a>	10% co-insurance	10% co-insurance	None
	<a href="#">Habilitation services</a>	10% co-insurance	10% co-insurance	Speech Therapy 60 lifetime maximum
	<a href="#">Skilled nursing care</a>	No charge	\$0 on first \$2,000 charges then 10% co-insurance	Limited to 180 days per condition
	<a href="#">Durable medical equipment</a>	10% co-insurance	10% co-insurance	\$100 deductible per family per year
	<a href="#">Hospice services</a>	No charge	\$0 on first \$2,000 charges then 10% co-insurance	Limited to 60 visits
If your child needs dental or eye care	Children's eye exam	10% co-insurance	10% co-insurance	Medical conditions of eye only. See vision plan for routine exam for visual acuity or eyewear.
	Children's glasses	Not Covered	Not Covered	Covered by separate vision plan.
	Children's dental check-up	Not Covered	Not Covered	Covered by separate dental plan.

#### Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |                         |  |                            |
|-------------------------|--|----------------------------|
| • Cosmetic surgery      | • Long-term care                                     | • Private-duty nursing     |
| • Dental care (Adult)   | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |
| • Infertility treatment |  | • Routine foot care        |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture (limited benefit)
- Chiropractic care (limited benefit)
- Weight loss programs (if meeting plan criteria)
- Bariatric surgery (if meeting plan criteria)
- Hearing aids (limited benefit)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 on how 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: Northwest Administrators at 1-800-458-3053 or [www.nwadmin.com](http://www.nwadmin.com). You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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 1-800-458-3053.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-458-3053.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-458-3053.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-458-3053.

*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 coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$600

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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The total Peg would pay is	\$600
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### 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 coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a> <sup>1</sup>	\$100
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$200

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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The total Joe would pay is	\$300
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### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$300

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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The total Mia would pay is	\$300
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\*Assumes the Health Assessment is not taken

<sup>1</sup>Durable Medical Supplies benefit deductible



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Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	\$200 individual/\$600 family. Goes to \$100 individual/\$300 family if you complete the Health Assessment, \$300 individual/\$900 family if you don't. Shared in and out-of-network.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	In-network <a href="#">provider</a> : \$1,500 Individual / \$4,500 Family. There is also an ACA in-network limit of \$10,600 individual/ \$21,200 family. Shared in and out-of-network	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the out-of-pocket limit?</a>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-888-901-4636 (TTY: 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan</a> 's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<a href="#">Do you need a referral to see a specialist?</a>	Yes, but you may self-refer to certain <a href="#">specialists</a> .	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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
		In-network Provider (You will pay the least)	<a href="#">Out-of-Network Provider</a> (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$20 / visit, <a href="#">deductible</a> does not apply.	\$20 / visit, <a href="#">deductible</a> does not apply.	None
	<a href="#">Specialist</a> visit	\$20 / visit, <a href="#">deductible</a> does not apply.	\$20 / visit, <a href="#">deductible</a> does not apply.	None
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply.	\$20 / visit, then 30% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required
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>	Value based drugs	\$4 (retail)		Up to a 30-day supply (retail); up to a 90-day supply (mail order). No charge for contraceptives. Subject to <a href="#">formulary</a> guidelines.
	Preferred generic drugs (Tier 1)	\$8 (retail); \$5 discount from retail <a href="#">cost share</a> (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.	\$13 (retail);, <a href="#">deductible</a> does not apply.	
	Preferred brand drugs (Tier 2)	\$25 (retail); \$5 discount from retail <a href="#">cost share</a> (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.	\$30 (retail);, <a href="#">deductible</a> does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.
	Non-preferred drugs (Tier 3)	\$50 (retail); \$5 discount from retail <a href="#">cost share</a> (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.	\$55 (retail), <a href="#">deductible</a> does not apply	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines .
	<a href="#">Specialty drugs</a>	Applicable Preferred generic, Preferred brand or Non-Preferred <a href="#">cost shares</a> apply.	Applicable Preferred generic, Preferred brand, or Non-Preferred <a href="#">cost shares</a> apply.	Up to a 30-day supply (retail). Subject to <a href="#">formulary</a> guidelines, when approved through the exception process.
If you have	Facility fee (e.g.,	\$20 / visit, then 10%	\$20 / visit, then 30%	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
outpatient surgery	ambulatory surgery center)	<u>coinsurance</u>	<u>coinsurance</u>	
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$75 / visit, then 10% <u>coinsurance</u>	\$75 / visit, then 10% <u>coinsurance</u>	You must notify Kaiser Permanente within 24 hours if admitted to an <u>out-of-network provider</u> ; limited to initial emergency only. <u>Copayment</u> waived if admitted directly to the hospital as an inpatient.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	None
	<u>Urgent care</u>	\$20 / visit	\$20 / visit , <u>deductible</u> does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit , <u>deductible</u> does not apply.	\$20 / visit , <u>deductible</u> does not apply.	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required
If you are pregnant	Office visits	10% <u>coinsurance</u>	\$20 / visit , <u>deductible</u> does not apply.	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.
If you need help recovering or have other special health	<u>Home health care</u>	No Charge	30% <u>coinsurance</u>	130 visit limit / year. Limits combined with in and <u>out-of-network provider networks</u> . <u>Preauthorization</u> required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
needs	<a href="#">Rehabilitation services</a>	Outpatient: \$20 / visit , <a href="#">deductible</a> does not apply. Inpatient: 10% <a href="#">coinsurance</a>	Outpatient: \$20 / visit , <a href="#">deductible</a> does not apply. Inpatient: 30% <a href="#">coinsurance</a>	Combined with <a href="#">Habilitation services</a> : Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, <a href="#">preauthorization</a> required or will not be covered. Limits are combined with in and <a href="#">out-of-network provider networks</a> .
	<a href="#">Habilitation services</a>	Outpatient: \$20 / visit , <a href="#">deductible</a> does not apply. Inpatient: 10% <a href="#">coinsurance</a>	Outpatient: \$20 / visit , <a href="#">deductible</a> does not apply. Inpatient: 30% <a href="#">coinsurance</a>	Combined with <a href="#">Rehabilitation services</a> : Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, <a href="#">preauthorization</a> required or will not be covered. Limits are combined with in and <a href="#">out-of-network provider networks</a> .
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	180-day limit / year. Limits are combined with in and <a href="#">out-of-network provider networks</a> . <a href="#">Preauthorization</a> required
	<a href="#">Durable medical equipment</a>	No charge, <a href="#">deductible</a> does not apply.	No charge, <a href="#">deductible</a> does not apply.	Subject to <a href="#">formulary</a> guidelines. <a href="#">Preauthorization</a> required
	<a href="#">Hospice services</a>	No charge, <a href="#">deductible</a> does not apply.	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required
If your child needs dental or eye care	Children's eye exam	\$20 / visit for refractive exam, <a href="#">deductible</a> does not apply.	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 policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |                                 |  |                        |
|---------------------------------|--|------------------------|
| • Children's glasses            | • Infertility treatment                              | • Private-duty nursing |
| • Cosmetic surgery              | • Long-term care                                     | • Routine foot care    |
| • Dental care (Adult and child) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                                      |   |                            |
|--------------------------------------|---|----------------------------|
| • Acupuncture (8 visit limit / year) | • Chiropractic care (20 visit limit / year) | • Routine eye care (Adult) |
| • Bariatric surgery                  | • Hearing aids (1 aid / ear / 36 months)    |                            |

**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 on how 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	1-888-901-4636 (TTY: 711) or <a href="http://www.kp.org">www.kp.org</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> .
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**

[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 No**

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 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-901-4636 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-901-4636 (TTY: 711).

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-888-901-4636 (TTY: 711) uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-901-4636 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-901-4636 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-888-901-4636 (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 [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other (blood work) [coinsurance](#) 10%

This EXAMPLE event includes services like:  
[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$1,230</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other (blood work) [coinsurance](#) 10%

This EXAMPLE event includes services like:  
[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$40
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$740</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other (x-ray) [coinsurance](#) 10%

This EXAMPLE event includes services like:  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.