KAISER PERMANENTE®

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Kaiser Foundation Health Plan of Washington: Spokane Transit Authority

Coverage Period: 1/1/2018 – 1/1/2019
Coverage for: Group | Plan Type: HMO

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, go to www.kp.org/wa or by calling 1-888-901-4636. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-888-901-4636 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$350 individual/$700 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the 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?	Does not apply to preventive care, prescription drugs, emergency medical transportation, durable medical equipment and eye exams.	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 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?	$2,000 individual/$4,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	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 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 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)	Non-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	Not covered	Manipulative therapy limited to 10 visits per calendar year, and naturopathy limited to 3 visits per medical diagnosis per calendar year, additional visits are covered with preauthorization or will not be covered. Acupuncture is limited to 12 visits per calendar year.
	Specialist visit	$40 copayment/visit	Not covered	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)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$40 copayment	Not covered	High end radiology imaging services such as CT, MRI and PET require preauthorization 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.	Value based drugs Preferred generic drugs	$5 copayment/prescription $20 copayment/prescription Deductible does not apply	Not covered	Covers up to a 30-day supply
	Preferred brand drugs	$40 copayment/prescription Deductible does not apply	Not covered	Covers up to a 30-day supply
	Non-preferred generic/brand drugs	50% coinsurance/prescription up to $250 Deductible does not apply	Not covered	Covers up to a 30-day supply
	Mail-order drugs	Value, $10 copayment/prescription; preferred generic, $40	Available when dispensed through the Kaiser Permanente	Covers up to a 30-day supply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
		copayment/prescription; preferred brand, $80 copayment/prescription; 50% coinsurance/prescription up to $750 Deductible does not apply	designated mail order service.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	$200 copayment/visit	Not covered	None
If you need immediate medical attention	Emergency room care	$300 copayment	$300 copayment	Notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible, copayment is waived if admitted.
	Emergency medical transportation	20% benefit specific coinsurance Deductible does not apply	20% benefit specific coinsurance Deductible does not apply	None
	Urgent care	$20 copayment/visit	$300 copayment	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment/day up to $1,000/admit	Not covered	Non-emergency inpatient services require preauthorization or will not be covered.
	Physician/surgeon fees	Included with Facility fee	Not covered	Non-emergency inpatient services require preauthorization or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment/visit	Not covered	None
	Inpatient services	$200 copayment/day up to $1,000/admit	Not covered	Non-emergency inpatient services require preauthorization or will not be covered.
If you are pregnant	Office visits	$20 copayment/visit	Not covered	Preventive services related to prenatal and preconception care are covered as preventive care. Routine care is covered as preventive care and not subject to the copayment.
	Childbirth/delivery professional services	Included with Facility fee	Not covered	Notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate

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				from that of the mother.
	Childbirth/delivery facility services	$200 copayment/day up to $1,000/admit	Not covered	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 Deductible does not apply	Not covered	Requires preauthorization or will not be covered.
	Rehabilitation services	$40 copayment/visit for outpatient $200 copayment/day up to $1,000/admit for inpatient	Not covered	Limited to 60 visits per calendar year/outpatient. Limited to 60 days per calendar year/inpatient (combined limit with Habilitation services). Services with mental health diagnoses are covered with no limit.
	Habilitation services	$40 copayment/visit for outpatient $200 copayment/day up to $1,000/admit for inpatient	Not covered	Limited to 60 visits per calendar year/outpatient. Limited to 60 days per calendar year/inpatient (combined limit with Rehabilitation services). Services with mental health diagnoses are covered with no limit.
	Skilled nursing care	No charge	Not covered	Limited to 150 days per calendar year. Requires preauthorization or will not be covered.
	Durable medical equipment	20% benefit-specific coinsurance Deductible does not apply	Not covered	Requires preauthorization or will not be covered.
	Hospice services	No charge Deductible does not apply	Not covered	Requires preauthorization or will not be covered.
If your child needs dental or eye care	Children's eye exam	$20 copayment/visit Deductible does not apply	Not covered	Limited to one exam every 12 months
	Children's glasses	No charge Deductible does not apply for network provider	Not covered	Members age 19 and over limited to $150 every 24 months; Members under age 19 limited to 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance
	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 dental check-up	• Long-term care	• Routine foot care
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Infertility treatment	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Hearing aids ($800/36 months)
• Bariatric surgery	• Dental care (Adult)	• Routine eye care (Adult)

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: Employee Benefits Security Administration at 1-866-444-3272 or 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Washington Office of Insurance Commissioner at: www.insurance.wa.gov/your-insurance/health-insurance/appeal. The Insurance Consumer Hotline at 1-800-562-6900 or access to a page to email the same office: www.insurance.wa.gov/ask-us-insurance-question. Or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 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	$40
Hospital (facility) copayment	$200
Other (blood work) coinsurance	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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$450

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	$40
Hospital (facility) copayment	$200
Other (blood work) coinsurance	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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$1,400
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,830

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

The plan's overall deductible	$350
Specialist copayment	$40
Hospital (facility) copayment	$200
Other (x-ray) coinsurance	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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$650

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