

<b>Effective Date</b> 11/1/2017	<b>Health Plan</b> Core HMO	<b>Ref</b> RQ-112862
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This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

<b>Benefits</b>	<b>Inside Network</b>
<b>Plan deductible</b>	No annual deductible
<b>Individual deductible carryover</b>	Not applicable
<b>Plan coinsurance</b>	Plan pays 90%, you pay 10%
<b>Out-of-pocket limit</b>	Individual out-of-pocket limit: \$1,000 Family out-of-pocket limit: \$2,000  Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:  All cost shares for covered services
<b>Pre-existing condition (PEC) waiting period</b>	No PEC
<b>Lifetime maximum</b>	Unlimited
<b>Outpatient services (Office visits)</b>	\$20 copay, coinsurance applies
<b>Hospital services</b>	<b>Inpatient services:</b> \$200 copay, per day for up to 3 days per admit Coinsurance applies <b>Outpatient surgery:</b> \$20 copay, coinsurance applies
<b>Prescription drugs (some injectable drugs may be covered under Outpatient services)</b>	Preferred generic/preferred brand/non-preferred \$10/\$20/\$40 copay per 30 day supply
<b>Prescription mail order</b>	2 x prescription cost share per 90 day supply
<b>Acupuncture</b>	Covered up to 12 visits per calendar year \$20 copay, coinsurance applies
<b>Ambulance services</b>	Plan pays 80%, you pay 20%
<b>Chemical dependency</b>	<b>Inpatient:</b> \$200 copay, per day for up to 3 days per admit Coinsurance applies <b>Outpatient:</b> \$20 copay, coinsurance applies
<b>Devices, equipment and supplies</b>	Covered at 80% <ul style="list-style-type: none"> <li>• Durable medical equipment</li> <li>• Orthopedic appliances</li> <li>• Post-mastectomy bras limited to two (2) every six (6) months</li> <li>• Ostomy supplies</li> <li>• Prosthetic devices</li> </ul>
<b>Diabetic supplies</b>	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
<b>Diagnostic lab and X-ray services</b>	<b>Inpatient:</b> Covered under Hospital services <b>Outpatient:</b> Deductible and coinsurance apply  High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.


<b>Emergency services</b> (copay waived if admitted)	\$150 copay at a designated facility \$150 copay at a non designated facility Coinsurance applies
<b>Hearing exams (routine)</b>	\$20 copay, coinsurance applies
<b>Hearing hardware</b>	Not covered
<b>Home health services</b>	Covered in full. No visit limit.
<b>Hospice services</b>	Covered in full
<b>Infertility services</b>	Not covered
<b>Manipulative therapy</b>	Covered up to 20 visits per calendar year without prior authorization \$20 copay, coinsurance applies
<b>Massage services</b>	See Rehabilitation services
<b>Maternity services</b>	<b>Inpatient:</b> \$200 copay, per day for up to 3 days per admit Coinsurance applies <b>Outpatient:</b> \$20 copay, coinsurance applies. Routine care not subject to outpatient services copay.
<b>Mental Health</b>	<b>Inpatient:</b> \$200 copay, per day for up to 3 days per admit Coinsurance applies <b>Outpatient:</b> \$20 copay, coinsurance applies
<b>Naturopathy</b>	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$20 copay, coinsurance applies
<b>Newborn Services</b>	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
<b>Obesity-related surgery (bariatric)</b>	Not covered
<b>Organ transplants</b>	Unlimited, no waiting period  <b>Inpatient:</b> \$200 copay, per day for up to 3 days per admit Coinsurance applies <b>Outpatient:</b> \$20 copay, coinsurance applies
<b>Preventive care</b> Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full  Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.
<b>Rehabilitation services</b> Rehabilitation visits are a total of combined therapy visits per calendar year	<b>Inpatient:</b> 30 days per calendar year. Services with mental health diagnoses are covered with no limit. \$200 copay, per day for up to 3 days per admit Coinsurance applies <b>Outpatient:</b> 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. \$20 copay, coinsurance applies
<b>Skilled nursing facility</b>	Up to 60 days per calendar year, coinsurance applies
<b>Sterilization</b> (vasectomy, tubal ligation)	<b>Inpatient:</b> \$200 copay, per day for up to 3 days per admit Coinsurance applies <b>Outpatient:</b> \$20 copay, coinsurance applies  Women's sterilization procedures are covered in full.
<b>Temporomandibular Joint (TMJ) services</b>	<b>Inpatient:</b> \$200 copay, per day for up to 3 days per admit Coinsurance applies <b>Outpatient:</b> \$20 copay, coinsurance applies
<b>Tobacco cessation counseling</b>	Quit for Life Program - covered in full
<b>Routine vision care</b> (1 visit every 12 months)	\$20 copay, coinsurance waived
<b>Optical hardware</b> Lenses, including contact lenses and frames	<b>Members under 19:</b> 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance <b>Members age 19 and over:</b> \$100 per 12 months  Not subject to coinsurance



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](http://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](http://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 <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Yes, \$1,000 individual/\$2,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.kp.org/wa">www.kp.org/wa</a> or call 1-888-901-4636 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes. See <a href="http://www.kp.org/wa">www.kp.org/wa</a> or call 1-888-901-4636 for a list of <u>specialist providers</u> .	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> /visit + 10% <u>coinsurance</u>	Not covered	Manipulative therapy limited to 20 visits per calendar year, and naturopathy limited to 3 visits per medical diagnosis per calendar year, additional visits are covered with <u>preauthorization</u> or will not be covered. Acupuncture is limited to 12 visits per calendar year.
	<u>Specialist</u> visit	\$20 <u>copayment</u> /visit + 10% <u>coinsurance</u>	Not covered	None
	<u>Preventive care/screening/immunization</u>	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 <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	Not covered	High end radiology imaging services such as CT, MRI and PET require <u>preauthorization</u> or will not be covered.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.kp.org/wa">www.kp.org/wa</a> .	Preferred generic drugs	\$10 <u>copayment/prescription</u>	Not covered	Covers up to a 30-day supply
	Preferred brand drugs	\$20 <u>copayment/prescription</u>	Not covered	Covers up to a 30-day supply
	Non-preferred generic/brand drugs	\$40 <u>copayment/prescription</u> <u>Deductible</u> does not apply	Not covered	Covers up to a 30-day supply
	Mail-order drugs	Member pays two times the <u>prescription drug cost share</u>	Available when dispensed through the Kaiser Permanente designated mail order service.	Covers up to a 90-day supply
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	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)	Non-network Provider (You will pay the most)	
	Physician/surgeon fees	\$20 <u>copayment</u> /visit + 10% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copayment</u> + 10% <u>coinsurance</u>	\$150 <u>copayment</u> + 10% <u>coinsurance</u>	Notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible, <u>copayment</u> is waived if admitted.
	<u>Emergency medical transportation</u>	20% benefit specific <u>coinsurance</u>	20% benefit specific <u>coinsurance</u>	None
	<u>Urgent care</u>	\$20 <u>copayment</u> /visit + 10% <u>coinsurance</u>	\$150 <u>copayment</u> + 10% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copayment</u> /day up to \$600/admit + 10% <u>coinsurance</u>	Not covered	Non-emergency inpatient services require <u>preauthorization</u> or will not be covered.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	Non-emergency inpatient services require <u>preauthorization</u> or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment</u> /visit + 10% <u>coinsurance</u>	Not covered	None
	Inpatient services	\$200 <u>copayment</u> /day up to \$600/admit + 10% <u>coinsurance</u>	Not covered	Non-emergency inpatient services require <u>preauthorization</u> or will not be covered.
If you are pregnant	Office visits	\$20 <u>copayment</u> /visit + 10% <u>coinsurance</u>	Not covered	<u>Preventive services</u> related to prenatal and preconception care are covered as <u>preventive care</u> . Routine care is covered as <u>preventive care</u> and not subject to the <u>copayment</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not covered	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	\$200 <u>copayment</u> /day up to \$600/admit + 10% <u>coinsurance</u>	Not covered	Newborn services <u>cost shares</u> are separate from that of the mother.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	Requires <u>preauthorization</u> or will not be covered.
	<u>Rehabilitation services</u>	\$20 <u>copayment</u> /visit + 10% <u>coinsurance</u> for	Not covered	Limited to 45 visits per calendar year/outpatient. Limited to 30 days per

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)	
		outpatient  \$200 <u>copayment</u> /day up to \$600/admit + 10% <u>coinsurance</u> for inpatient		calendar year/inpatient. (combined limit with <u>Habilitation services</u> ). Services with mental health diagnoses are covered with no limit.
	<u>Habilitation services</u>	\$20 <u>copayment</u> /visit + 10% <u>coinsurance</u> for outpatient  \$200 <u>copayment</u> /day up to \$600/admit + 10% <u>coinsurance</u> for inpatient	Not covered	Limited to 45 visits per calendar year/outpatient. Limited to 30 days per calendar year/inpatient. (combined limit with <u>Rehabilitation services</u> ). Services with mental health diagnoses are covered with no limit.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not covered	Limited to 60 days per calendar year. Requires <u>preauthorization</u> or will not be covered.
	<u>Durable medical equipment</u>	20% benefit-specific <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> or will not be covered.
	<u>Hospice services</u>	No charge	Not covered	Requires <u>preauthorization</u> or will not be covered.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$20 <u>copayment</u> /visit	Not covered	Limited to one exam every 12 months
	Children's glasses	No charge <u>Deductible</u> does not apply for <u>network provider</u>	Not covered	Members age 19 and over limited to \$100 every 12 months; Members under age 19 limited to 1 pair of frames and lenses per year or contact lenses covered at 50% <u>coinsurance</u>
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- 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](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 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](http://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](http://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](http://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, kwijigo 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 cost sharing \$20+10%
- Hospital (facility) cost sharing \$200+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>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,060</b>

**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 cost sharing \$20+10%
- Hospital (facility) cost sharing \$200+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>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,060</b>

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

- The plan's overall deductible \$0
- Specialist cost sharing \$20+10%
- Hospital (facility) cost sharing \$200+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>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>