


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 1/1/2020 – 12/31/2020

 KAISER PERMANENTE: Washington Teamsters Welfare Trust

Coverage for: Individual / Family | Plan Type: POS

All plans offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.

 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, see www.kp.org/plandocuments or call 1-888-901-4636 (TTY: 711). 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 <http://www.healthcare.gov/sbc-glossary> or call 1-888-901-4636 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$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 <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other Family members on the <u>plan</u> , each Family member must meet their own Individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all Family members meets the overall Family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and services indicated in chart starting on page 2.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$1,500 individual/ \$4,500 family shared in and out-of-network limit. There is also an ACA in-network limit of \$8,150 individual/ \$16,300 family. Shared in and out-of-network	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</u> limits until the overall Family <u>out-of-pocket</u> limit has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and services indicated in chart starting on page 2.	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 network provider?	Yes. See www.kp.org/wa or call 1-888-901-4636 (TTY: 711) 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 <u>provider's</u> 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 referral to see a specialist?	Yes, but you may self-refer to certain <u>specialists</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
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 / visit <u>Deductible</u> does not apply	\$20 / visit <u>Deductible</u> does not apply	None
	<u>Specialist</u> visit	\$20 / visit <u>Deductible</u> does not apply	\$20 / visit <u>Deductible</u> does not apply	None
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	\$20 / visit, 30% <u>coinsurance</u>	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required or will not be covered.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/wa .	Value based drugs Preferred generic drugs (Tier 1)	Retail: \$4 / prescription Retail: \$8 / prescription; Mail Order: \$5 discount from retail <u>cost share</u> / prescription <u>Deductible</u> does not apply	Retail: \$13 / prescription <u>Deductible</u> does not apply	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to <u>formulary</u> guidelines.
	Preferred brand drugs (Tier 2)	Retail: \$25 / prescription; Mail Order: \$5 discount from retail <u>cost share</u> / prescription <u>Deductible</u> does not apply	Retail: \$30 / prescription <u>Deductible</u> does not apply	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to <u>formulary</u> guidelines.
	Non-preferred generic/brand drugs (Tier 3)	Retail: \$50 / prescription Mail Order: \$5 discount from retail <u>cost share</u> / prescription <u>Deductible</u> does not apply	Retail: \$55 / prescription <u>Deductible</u> does not apply	Up to a 30-day supply (retail) or a 90-day supply (mail order). Subject to <u>formulary</u> guidelines.
	<u>Specialty drugs</u>	Applicable preferred generic, preferred brand, or non-preferred generic/brand <u>cost shares</u> may apply. <u>Deductible</u> does not apply	Applicable preferred generic, preferred brand, or non-preferred generic/brand <u>cost shares</u> may apply. <u>Deductible</u> does not apply	Up to a 30-day supply (retail). Subject to <u>formulary</u> guidelines.

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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$20 / visit, 10% <u>coinsurance</u>	\$20 / visit, 30% <u>coinsurance</u>	None
	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, 10% <u>coinsurance</u>	\$75 / visit, 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 <u>Deductible</u> does not apply	\$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 or will not be covered.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required or will not be covered.
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 or will not be covered.
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 to certain <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.

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)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge <u>Deductible</u> does not apply	30% <u>coinsurance</u>	130 visit limit / year. <u>Preauthorization</u> required or will not be covered.
	<u>Rehabilitation services</u>	Outpatient: \$20 / visit <u>Deductible</u> does not apply	Outpatient: \$20 / visit <u>Deductible</u> does not apply	Outpatient: 60 visit limit / year. Inpatient: 60 day limit / year (combined with <u>Habilitation services</u>).
		Inpatient: 10% <u>coinsurance</u>	Inpatient: 30% <u>coinsurance</u>	Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Habilitation services</u>	Outpatient: \$20 / visit <u>Deductible</u> does not apply	Outpatient: \$20 / visit <u>Deductible</u> does not apply	Outpatient: 60 visit limit / year. Inpatient: 60 day limit / year (combined with <u>Rehabilitation services</u>).
		Inpatient: 10% <u>coinsurance</u>	Inpatient: 30% <u>coinsurance</u>	Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	180 day limit / year. Limits are combined with in and out-of-network provider networks. <u>Preauthorization</u> required or will not be covered.
<u>Durable medical equipment</u>	No charge <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply	Subject to <u>formulary</u> guidelines. <u>Preauthorization</u> required or will not be covered.	
<u>Hospice services</u>	No charge <u>Deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> required or will not be covered.	
If your child needs dental or eye care	Children's eye exam	\$20 / visit <u>Deductible</u> does not apply	Not covered	Limited to one 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.)

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| • Children's glasses | • Infertility treatment | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult & 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.)

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| • Acupuncture (8 visit limit / year) | • Chiropractic care (20 visit limit / year) | • Routine eye care (Adult) |
| • Bariatric surgery | • Hearing aids (\$1,000 / 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 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 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 www.kp.org/wa
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov .
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

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 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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, kwijigo holne' 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 \$300
- 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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,290

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$300
- 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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,270

Mia's Simple Fracture

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

- The plan's overall deductible \$300
- 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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

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