



All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest



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

<https://kp.org/plandocuments> or call 1-800-813-2000 (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 www.healthcare.gov/sbc-glossary/ or call 1-800-813-2000 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$600 Individual / \$1,200 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, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-800-813-2000 (TTY: 711) for a list of Participating 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, but you may self-refer to certain specialists .	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 Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	None
	Specialist visit	No charge	Not covered	None
	Preventive care/ screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Xray: No charge. Lab tests: No charge	Not covered	None
	Imaging (CT/PET scans, MRI's)	No charge	Not covered	Some services may require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	\$10 (retail) & \$20 (mail order) / prescription .	Not covered	Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs	\$20 (retail) & \$40 (mail order) / prescription .	Not covered	Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	\$20 (retail) & \$40 (mail order) / prescription .	Not covered	Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through exception process.
	Specialty drugs	\$20 (retail) / prescription	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through exception process.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	\$75 / visit	\$75 / visit	Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	\$75 / trip	\$75 / trip	None
	Urgent care	No charge	Not covered	Non-Participating Providers covered when temporarily outside the service area: No charge
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Prior authorization required.
	Physician/surgeon fee	No charge	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	None
	Inpatient services	No charge	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	130 visit limit / year. Prior authorization required.
	Rehabilitation services	Outpatient: No charge Inpatient: No charge	Not covered	Outpatient: 20 visit limit / year. Prior authorization required. Inpatient: Prior authorization required.
	Habilitation services	No charge	Not covered	20 visit limit / year. Prior authorization required.
	Skilled nursing care	No charge	Not covered	100 day limit / year. Prior authorization required.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Prior authorization required.
	Hospice service	No charge	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam	Not covered	None
	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 Cosmetic surgery Dental care (Adult & Child)	Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing	Routine foot care Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

Acupuncture (12 visit limit / year) Bariatric surgery	Chiropractic care (12 visit limit / year) Hearing aids (1 aid / ear / 36 months)	Infertility treatment Routine eye care (Adult)
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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 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	1-800-813-2000 (TTY: 711) or www.kp.org/memberservices
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
Oregon Department of Insurance	1-888-877-4894 or https://dfr.oregon.gov/
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

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 1-800-813-2000 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-813-2000 (TTY: 711)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-813-2000 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-813-2000 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-813-2000 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-813-2000 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-800-813-2000 (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	\$0
Specialist copayment	\$0
Hospital (facility) copayment	\$0
Other (blood work) copayment	\$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	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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 copayment	\$0
Hospital (facility) copayment	\$0
Other (blood work) copayment	\$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	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$510

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

The plan's overall deductible	\$0
Specialist copayment	\$0
Hospital (facility) copayment	\$0
Other (x-ray) copayment	\$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	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$250

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

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

Qualified sign language interpreters

Written information in other formats, such as large print, audio, braille, and accessible electronic formats

Provide no cost language services to people whose primary language is not English, such as:

Qualified interpreters

Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: 711).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department

Attention: Kaiser Civil Rights Coordinator

500 NE Multnomah St., Suite 100

Portland, OR 97232-2099

Fax: **1-855-347-7239**

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

U.S. Department of Health and Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, DC 20201

Phone: **1-800-368-1019**

TDD: **1-800-537-7697**

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For Washington Members:

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 1-800-562-6900, or 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/ocic/online-services/cc/pub/complaintinformation.aspx>.

This notice is available at <https://healthy Kaiserpermanente.org/oregon-washington/language-assistance/non-discrimination-notice>

Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call 1-800-813-2000 (TTY: 711).

(Amharic)

1-800-813-2000

(TTY: 711)

پیارگا (Arabic) بیتھی: إلزامك تفتت ثدح لغایقی رتتفو لغی خت امدل ا قد علمن ملیق و غب ام فیل ذک من سولھی ال اقد علمن و ت امد غی ال اینھن ملیمن اجمت الصل لبلقیر
(TTY: 711) 1-800-813-2000

中文 (Chinese) 注意事項: 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 1-800-813-2000 (TTY: 711)。

**پس راف (Farsi) فوج گارب مبز نافلیس رص بتبح یک چی، «بیت تای هبزین»، زا ج فیک کم اه و خت امد شیون بیت ن مبیس اب هص ترو رن گیا درسید سرت نا
تس ابل 1-800-813-2000 اتس ام گھیری (TTY: 711) فلت نت ھن:**

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le 1-800-813-2000 (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie 1-800-813-2000 an (TTY: 711).

日本語 (Japanese) 注意: 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。1-800-813-2000 までお電話ください (TTY: 711)。

(Khmer)

1-800-813-2000 (TTY: 711).

(Korean) :
(TTY: 711).

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1-800-813-2000

ລາວ (Laotian) ແກ້ວມະນີ: ແກ້ວມະນີ, ແກ້ວມະນີ ແກ້ວມະນີ ແກ້ວມະນີ ແກ້ວມະນີ ແກ້ວມະນີ ແກ້ວມະນີ
1-800-813-2000 (TTY: 711).

Afaan Oromoo (Oromo) XIYYEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. 1-800-813-2000 irratti bilbilaa (TTY 711)

(Punjabi) :
1-800-813-2000 (TTY 711).

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutorare și servicii auxiliare adecvate. Sunați la 1-800-813-2000 (TTY: 711).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру 1-800-813-2000 (TTY: 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al 1-800-813-2000 (TTY: 711).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: 711).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ยานสามารถขอรับบริการ
(TTY: 711). **อดั๊กานภรณ์ อดั๊กานภรณ์** การเสริมที่ **หนึ่งพันแปด
พันสามร้อยเอ็ด-สองพันศูนย์**

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовою допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером 1 800 813 2000 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: 711).