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

Coverage Period: Beginning on or after 01/01/2027

KAISER PERMANENTE® : **KP WA Silver KP Plus 3000**

Coverage for: Individual / Family | Plan Type: EPO

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?	$3,000 Individual / $6,000 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?	Yes. Preventive care and services indicated in chart starting on page 2.	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?	$10,200 Individual / $20,400 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 billing charges, 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 In-network Providers.	You pay the least if you use a provider in the In-Network Provider tier. 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).
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 In-Network (You will pay the least)	What You Will Pay Out-Of-Network (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	$40 / visit, deductible does not apply	$60 / visit, deductible does not apply	Out-of-Network Provider: Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Specialist visit	$60 / visit, deductible does not apply	$80 / visit, deductible does not apply	Out-of-Network Provider: Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Preventive care/ screening/ immunization	No charge, deductible does not apply	No charge, deductible does not apply	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. Out-of-Network Provider: Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
If you have a test	Diagnostic test (x-ray, blood work)	Xray: $40 / visit, deductible does not apply. Lab tests: $50 / visit, deductible does not apply.	Xray: $60 / visit, deductible does not apply. Lab tests: $70 / visit, deductible does not apply.	Out-of-Network Provider: Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Imaging (CT/PET scans, MRI's)	40% coinsurance	Not covered	Some services may require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay In-Network (You will pay the least)	What You Will Pay Out-Of-Network (You will pay the most)	Limitations, Exceptions & Other Important Information
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	$30 (retail) & $60 (mail order) / prescription, deductible does not apply.	$50 (retail) / prescription, deductible does not apply	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Out-of-Network Provider: Limited to a combined maximum of 5 prescription fills / year.
	Preferred brand drugs	$65 (retail) & $130 (mail order) / prescription, deductible does not apply.	$85 (retail) / prescription, deductible does not apply	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Out-of-Network Provider: Limited to a combined maximum of 5 prescription fills / year.
	Non-preferred drugs	50% coinsurance (retail & mail order), deductible does not apply	50% coinsurance (retail), deductible does not apply	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through exception process. Out-of-Network Provider: Limited to a combined maximum of 5 prescription fills / year.
	Specialty drugs	50% coinsurance (retail), deductible does not apply	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through exception process. Out-of-Network Provider: Limited to a combined maximum of 5 prescription fills / year.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	Prior authorization required.
	Physician/surgeon fees	40% coinsurance	Not covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	None
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	$70 / visit, deductible does not apply	$70 / visit, deductible does not apply	Out-of-Network Provider: only covered if you are out of the service area.

Common Medical Event	Services You May Need	What You Will Pay In-Network (You will pay the least)	What You Will Pay Out-Of-Network (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	Prior authorization required.
	Physician/surgeon fee	40% coinsurance	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 / visit, deductible does not apply	$60 / visit	Out-of-Network Provider: Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Inpatient services	40% coinsurance	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge, deductible does not apply	No charge, deductible does not apply	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). Out-of-Network Provider: Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Childbirth/delivery professional services	40% coinsurance	Not covered	None
	Childbirth/delivery facility services	40% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay In-Network (You will pay the least)	What You Will Pay Out-Of-Network (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	130 visit limit / year. Prior authorization required.
	Rehabilitation services	Outpatient: $60 / visit, deductible does not apply Inpatient: 40% coinsurance.	Outpatient: $80 / visit Inpatient: Not covered.	Outpatient: 25 visit limit / year. Prior authorization required. Inpatient: Prior authorization required. Out-of-Network Provider: Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Habilitation services	$60 / visit, deductible does not apply	$80 / visit	25 visit limit / year. Prior authorization required. Out-of-Network Provider: Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Skilled nursing care	40% coinsurance	Not covered	60 day limit / year. Prior authorization required.
	Durable medical equipment	40% coinsurance	Not covered	Subject to formulary guidelines. Prior authorization required.
	Hospice service	No charge, deductible does not apply	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam, deductible does not apply	$60 / visit for refractive exam, deductible does not apply	Limited to 1 exam / year. Out-of-Network Provider: Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Children's glasses	No charge, deductible does not apply	Not covered	Limited to one pair of selected frames and lenses or contact lenses / 12 months.
	Children's dental check-up	No charge, deductible does not apply	No charge, deductible does not apply	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
- Infertility treatment (except artificial insemination)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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 (12 visit limit / year) • Chiropractic care (10 visit limit / year)	• Hearing aids ((Adults: 1 / ear / 36 months; Under age 26: 1 aid / ear / 36 months)	• Infertility treatment

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 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, kwiijigo 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** **$60**
- **Hospital (facility) coinsurance** **40%**
- **Other (blood work) copayment** **$50**

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*	$3,000
Copayments	$10
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,770**

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** **$60**
- **Hospital (facility) coinsurance** **40%**
- **Other (blood work) copayment** **$50**

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*	$100
Copayments	$1,300
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,430**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **40%**
- **Other (x-ray) copayment** **$40**

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*	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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/lobby.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/oic/onlineservices/cc/pub/complaintinformation.aspx**.

This notice is available at **https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-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**).

አማርኛ (Amharic) ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: **711**)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-813-2000** . (TTY: **711**)

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**）。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-813-2000** تماس بگیرید (TTY (تلفن متنی): **711**).

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**）。

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖ បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសមស្រប ដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-800-813-2000** (TTY: **711**).

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-813-2000**로 전화해 주세요(TTY: **711**).

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: 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**)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- **711**).

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare 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 ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної 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**).