WASHINGTON TEAMSTERS WELFARE TRUST

IMPORTANT: Your action is required by December 15, 2020 to maintain your medical coverage and qualify for the 2021 Health Assessment incentive.

Annual Enrollment and Health Assessment | 2021

To ensure timely processing of medical claims for you and your family and qualify for the Health Assessment incentive, you must complete the following:

STEP 1: Update or verify your enrollment information online at www.nwadmin.com.

You must verify or update your enrollment information in order for your medical claims to be processed in 2021. If you have any questions or need a paper Annual Enrollment form, visit **wateamsters.com/annual-enrollment** or call Northwest Administrators at **(800) 458-3053**.

STEP 2: Choose to keep your current medical plan or opt to change medical plans by December 15, 2020.

The Trust is continuing to offer the same two medical plans for 2021. A Summary of Benefits and Coverage for each plan is enclosed.

- **Trust Medical Plan** - Allows you to choose in-network care at the highest level of coverage from Premera Blue Cross, or out-of-network care at a lower level of coverage from any licensed provider anywhere.

- **Kaiser Permanente Options Plan** - Allows you to choose in-network care at the highest level of coverage from Kaiser Permanente or one of its contracted providers, or out-of-network care at a lower level of coverage from First Choice Health, First Health, or any licensed provider anywhere.

If you re-enroll online at www.nwadmin.com, you will have the option to stay in your current medical plan or change plans after completing Step 1. ***Even if you do not want to change plans, you must still do Step 1.***

STEP 3: (Optional) Take your Health Assessment by December 15, 2020 to save hundreds off your 2021 medical expenses.

Take the optional Health Assessment (HA) by December 15, 2020 and your annual deductible in 2021 will be $200 less per person or up to $600 less per family. Note: If you are married or have a covered domestic partner, both of you must take the HA in order to get the lower deductibles.

If you were enrolled in the Trust Medical Plan for 2020 you must take the Health Assessment at **wateamsters.vivacity.com** or call Vivacity at (855) 784-4562 for a paper form.

If you were enrolled in Kaiser Permanente for 2020 you must take the Health Assessment (Health Profile) at **www.kp.org/wa** or call Kaiser Permanente at (866) 458-5277 for a paper form.

Plans A,B,C,Z

Frequently Asked Questions

Q. Do I need to do anything if I don't want to change my medical plan?

A. Yes, you must still re-enroll to verify or update your enrollment information even if you do not want to change medical plans. Here's how:

> Complete your re-enrollment online at **www.nwadmin.com**. Login (or register as a Participant if you haven't previously), then click on the Annual Enrollment link located on the left side of the screen. The Trust's Annual Enrollment program will let you review your current enrollment information and make changes or confirm that your enrollment information is current. It will guide you step-by-step through the process as well as give you the option to choose a medical plan.
>
> If you are unable to complete re-enrollment online, you may complete a paper form. Visit **wateamsters.com/annual-enrollment** to print the form or call Northwest Administrators at **(800) 458-3053** to request a form be sent to you. If you choose to re-enroll by paper, **you must complete the form in its entirety**, not just make changes or the plan selection.

Q. Are there any changes in the Trust Medical Plan benefits in 2021?

A. It should be noted that the annual out-of-pocket maximums for 2021 as mandated by the Affordable Care Act, which includes in-network medical and prescription out-of-pocket expenses for copays, deductibles, and coinsurance are $8,550 per person / $17,100 per family. The Trust has elected to split this maximum between medical services and prescription drugs. As a result, the annual out-of-pocket maximum for in-network Medical services under the Plan will be $5,000 per person / $10,000 per family. The in-network Prescription Drug Copay out-of-pocket maximum will be $3,550 per person / $7,100 per family.

Q. Are there any changes in the Kaiser Permanente Options Plan benefits in 2021?

A. As mandated by the Affordable Care Act, the annual out-of-pocket maximums for in-network medical services and prescription drug copays will be a combined $8,550 per person / $17,100 per family.

Q. What about my Trust coverage other than medical?

A. If your bargaining unit has other coverage through the Trust such as dental, vision, time loss, life insurance, disability waivers, etc., you will continue to qualify for these benefits regardless of your medical plan selection. If your bargaining unit elected vision coverage through the Trust, and you elect Kaiser Permanente Options, the Trust vision plan will be primary over the vision benefits provided through Kaiser Permanente.

Q. Where do I send my completed enrollment form?

A. If you enrolled online, then you are done. If you are unable to enroll online, visit **wateamsters.com/annual-enrollment** or call Northwest Administrators at **(800) 458-3053** to obtain a paper Annual Enrollment form (a paper form is not included in this packet). *Mail your completed enrollment form by December 15, 2020 to:*

Washington Teamsters Welfare Trust
Attn: Annual Enrollment
2323 Eastlake Avenue East
Seattle, WA 98102-3393

Q. If my spouse and I both have insurance, will benefits be coordinated?

A. Yes, both the Trust Medical and Kaiser plans coordinate benefits except for prescription drugs. Prescription drugs are coordinated only if both you and your spouse are covered under Trust Plans.

Q. Is there any additional cost to me if I select one plan over another?
A. No. Both plans are available at the same cost.

Q. Who is an eligible dependent?

A. Your eligible dependents are:

- Your spouse
- Your domestic partner ***if*** domestic partner benefits have been negotiated into your labor agreement
- Your children under age 26 who are your:
    - Natural children
    - Adopted children
    - Step children
    - Children placed with you for adoption
- The following children ***if*** they are under age 19, unmarried, live with you, and are dependent on you for support:
    - Children for whom you are the court-appointed guardian
    - Grandchildren
    - Children of your domestic partner ***if*** domestic partner benefits have been negotiated into your labor agreement

  This second group of children will be eligible until age 26 (through 25) only if they are unmarried, dependent on you for support, and are full-time students in an accredited educational institution.
- Your unmarried dependent child who is physically or mentally incapable of self-support

Note: If you are enrolling a new dependent or changing the status of a currently enrolled dependent, you must submit documentation to verify the dependent(s) eligibility. Such documentation may include, but is not limited to:

Spouse	Marriage Certificate
Child	Birth Certificate/Proof of Adoption
Grandchild	Birth certificates of your child and your grandchild and a copy of the first page of your most recent IRS Form 1040 listing your grandchild as a dependent (you may black out Social Security numbers and income information)
Ward	Court document showing your appointment as legal guardian (custody agreements are not acceptable)

Q. What is the Health Assessment and why should I take it?

A. The Health Assessment (HA) is a confidential questionnaire about health and lifestyle habits. The HA is quick and easy to complete and gives you immediate results to help you find ways to improve or maintain your health. You can also save hundreds of dollars in medical expenses when you and your spouse or domestic partner, if covered, both take the HA.

Q. Who do I call if I have questions about the medical plans or need more information?

A. **Trust Medical Plan** - Call Northwest Administrators at (800) 458-3053.

Kaiser Permanente Options Plan - Call Kaiser Permanente at (888) 901-4636. When calling Kaiser Permanente please be sure to reference the Washington Teamsters Welfare Trust and your medical Plan, or if you are currently a Kaiser member, have your Kaiser Permanente ID card available.

Sincerely,

The Board of Trustees
Washington Teamsters Welfare Trust

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, visit www.wateamsters.com or call **1-800-458-3053**. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-458-3053 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600** individual / **$1,800** family. Goes to $500 individual / $1,500 family if you complete the Health Assessment, $700 individual / $2,100 family if you don't.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. The deductible does not apply to in-network preventive care, office visits, prescription drugs, obesity programs.	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?	Yes. **$75** for outpatient emergency room visits.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$4,000** individual / **$8,000** family shared in and out-of-network medical coinsurance limit. In addition, an ACA mandated limit for in-network prescription drugs of **$3,550** individual / **$7,100** family and in-network medical of **$5,000** individual / **$10,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Not included in the medical **$4,000** individual / **$8,000** family coinsurance limit are premiums, deductibles, co-pays, non-covered charges and obesity care. Not included in the ACA mandated limit for in-network prescriptions and in-network medical are premiums, out-of-network and non-covered charges and obesity care.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.wateamsters.com and select Premera BlueCard Network Directory **or call 1-800-810-2583** for a list of participating providers. Be sure to reference the alpha prefix **TMP**. For prescription drugs see www.medimpact.com **or call 1-800-788-2949**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

⚠ 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)	Out-of-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	$30 co-pay/visit	$30 co-pay/visit	Applies to charge for the office visit only not other professional fees.
	Specialist visit	$30 co-pay/visit	$30 co-pay/visit	Applies to charge for the office visit only not other professional fees.
	Preventive care/screening/ immunization	No charge	50% co-insurance after deductible and $30 co-pay	None
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	50% co-insurance	None
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com	Generic drugs	Retail: 10% or 15% co-pay/prescription; Mail order: 10% co-pay/prescription to maximum $15	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	Preferred brand drugs	Retail: 30% or 35% co-pay/prescription; Mail order: 30% co-pay/prescription to maximum $90	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	Retail: 40% or 45% co-pay/prescription; Mail order: 40% co-pay/prescription to maximum $130	Not covered except for a medical emergency	Covers up to a 34-day supply (retail prescription); up to 100 day supply (mail order prescription). Lower retail co-pay % applies to recommended retail pharmacies.
	Specialty drugs	Mail Order only: 30% co-pay/prescription to maximum $90	Not covered except for a medical emergency	Mail Order only. Covers up to 100-day supply for mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance	None
	Physician/surgeon fees	30% co-insurance	50% co-insurance	None
If you need immediate medical attention	Emergency room care	After $75 deductible, 30% co-insurance	After $75 deductible, 30% co-insurance	Notify Plan within 24 hours of admission
	Emergency medical transportation	30% co-insurance	50% co-insurance	None
	Urgent care	30% co-insurance	50% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	Prior Authorization Required
	Physician/surgeon fees	30% co-insurance	50% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 co-pay/session	$10 co-pay/session	None
	Inpatient services	30% co-insurance	50% co-insurance	Prior Authorization Required
If you are pregnant	Office visits	30% co-insurance	50% co-insurance	Child's pregnancy is not covered.
	Childbirth/delivery professional services	30% co-insurance	50% co-insurance	Child's pregnancy is not covered.
	Childbirth/delivery facility services	30% co-insurance	50% co-insurance	Child's pregnancy is not covered.
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Limited to 130 visits per year
	Rehabilitation services	30% co-insurance inpatient $30 co-pay/visit outpatient	50% co-insurance inpatient $30 co-pay/visit outpatient	None - inpatient Limited to 24-48 visits per year for outpatient

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	30% co-insurance inpatient $30 co-pay/visit outpatient	50% co-insurance inpatient $30 co-pay/visit outpatient	None - inpatient Limited to 24-48 visits per year for outpatient
	Skilled nursing care	30% co-insurance	50% co-insurance	Limited to 180 days per condition
	Durable medical equipment	30% co-insurance	50% co-insurance	None
	Hospice services	30% co-insurance	50% co-insurance	Limited to 60 visits
If your child needs dental or eye care	Children's eye exam	30% co-insurance	50% co-insurance	Medical conditions of eye only. See vision plan for routine exam for visual acuity or eyewear.
	Children's glasses	Not Covered	Not Covered	Covered by separate vision plan.
	Children's dental check-up	Not Covered	Not Covered	Covered by separate dental plan.

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.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Acupuncture (limited benefit)
- Bariatric surgery (if meeting plan criteria)
- Chiropractic care (limited benefit)
- Hearing aids (limited benefit)
- Weight loss program (if meeting plan criteria)

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: the U.S. Department of Labor, 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 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: Northwest Administrators at 1-800-458-3053 or www.nwadmin.com. You can also contact 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

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 1-800-458-3053.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-458-3053.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-458-3053.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-458-3053.

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	**$700***
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$700
Copayments	$40
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,540**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$700***
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$700
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,360**

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

The plan's overall deductible	**$700***
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$775
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,425**

***Assumes the Health Assessment is not taken**

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

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, 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 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?	**$500** individual/ **$1,500** family Goes to $400 individual/ $1,200 family if you complete the Health Assessment, $600 individual / $1,800 family if you don't. Shared in and out-of-network.	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 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?	**$4,000** individual/**$12,000** family shared in and out-of-network limit. There is also an ACA in-network limit of **$8,550** individual/**$17,100** 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/wa or call 1-888-901-4636 (TTY: 711) 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, 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		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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 / visit, deductible does not apply.	$30 / visit, deductible does not apply.	None
	Specialist visit	$30 / visit, deductible does not apply.	$30 / visit, deductible does not apply.	None
	Preventive care/screening/ immunization	No charge, deductible does not apply.	$30 / visit, then 50% coinsurance	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)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Preauthorization required 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 (Tier 1)	$4 (retail); $8 (retail); $5 discount from retail cost share (mail order) / prescription, deductible does not apply.	$13 (retail);, deductible does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs (Tier 2)	$25 (retail); $5 discount from retail cost share (mail order) / prescription, deductible does not apply.	$30 (retail);, deductible does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs (Tier 3)	$50 (retail); $5 discount from retail cost share (mail order) / prescription deductible does not apply.	$55 (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 the exception process.
	Specialty drugs	Applicable Preferred generic, Preferred brand or Non-Preferred cost shares apply.	Applicable Preferred generic, Preferred brand, or Non-Preferred cost shares apply.	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30 / visit, then 30% coinsurance	$30 / visit, then 50% coinsurance	None

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)	
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$75 / visit, then 30% coinsurance	$75 / visit, then 30% coinsurance	You must notify Kaiser Permanente within 24 hours if admitted to an out-of-network provider; limited to initial emergency only. Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance, deductible does not apply.	20% coinsurance, deductible does not apply.	None
	Urgent care	$30 / visit, deductible does not apply.	$30 / visit, deductible does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization required or will not be covered.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 / visit, deductible does not apply.	$30 / visit, deductible does not apply.	None
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization required or will not be covered.
If you are pregnant	Office visits	30% coinsurance	$30 / visit, deductible does not apply.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. 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.	50% coinsurance	130 visit limit / year. Limits combined with in and out-of-network provider networks. Preauthorization required or will not be covered.

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)	
	Rehabilitation services	Outpatient: $30 / visit, deductible does not apply. Inpatient: 30% coinsurance	Outpatient: $30 / visit, deductible does not apply. Inpatient: 50% coinsurance	Combined with Habilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered. Limits are combined with in and out-of-network provider networks.
	Habilitation services	Outpatient: $30 / visit, deductible does not apply. Inpatient: 30% coinsurance	Outpatient: $30 / visit, deductible does not apply. Inpatient: 50% coinsurance	Combined with Rehabilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered. Limits are combined with in and out-of-network provider networks.
	Skilled nursing care	30% coinsurance	50% coinsurance	180-day limit / year. Limits are combined with in and out-of-network provider networks. Preauthorization required or will not be covered.
	Durable medical equipment	20% coinsurance, deductible does not apply.	20% coinsurance	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	No charge, deductible does not apply.	50% coinsurance	Preauthorization required or will not be covered.
If your child needs dental or eye care	Children's eye exam	$30 / visit for refractive exam, deductible does not apply.	Not covered	Limited to 1 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.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult and child)
- 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 (8 visit limit / year)
- Bariatric surgery
- Chiropractic care (20 visit limit / year)
- Hearing aids ($1,000 limit / ear / 36 months)
- 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 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	1-888-901-4636 (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
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 1-888-901-4636 (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, kwiijigo 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	**$600***
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other (blood work) coinsurance	**30%**

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	$600
Copayments	$10
Coinsurance	$3,300
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,930**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$600***
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other (blood work) coinsurance	**30%**

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	$50
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$850**

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

The plan's overall deductible	**$600***
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other (x-ray) coinsurance	**30%**

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	$600
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

***Assumes the Health Profile is not taken**

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