

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

Coverage Period: 01/01/2024-12/31/2024



KAISER PERMANENTE® : Jireh Semiconductor, Inc – TRAD PLAN L G Y E 15/1500

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 www.kp.org/plandocuments or call 1-800-813-2000 (TTY: 711). For 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 1-800-813-2000 (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 ?	\$1,500 Individual / \$3,000 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.

<p>Do you need a referral to see a specialist?</p>	<p>Yes, but you may self-refer to certain specialists.</p>	<p>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.</p>
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 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<p>If you visit a health care provider's office or clinic</p>	Primary care visit to treat an injury or illness	\$15 / visit	Not covered	\$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Specialist visit	\$25 / visit	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.
<p>If you have a test</p>	Diagnostic test (x-ray, blood work)	X-ray: \$15 / visit Lab tests: \$15 / visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$50 / visit	Not covered	Some services may require prior authorization.
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary</p>	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 brand drugs	\$40 (retail); \$80 (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	Applicable Generic, Preferred brand, Non-Preferred brand drug cost shares apply.	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		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 / visit	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need immediate medical attention	Emergency room care	\$200 / visit	\$200 / visit	Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	\$75 / trip	\$75 / trip	None
	Urgent care	\$35 / visit	Not covered	Non-Participating Providers covered when temporarily outside the service area: \$35 / visit
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 / day up to \$1,000 / admission	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / visit	Not covered	\$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Inpatient services	\$200 / day up to \$1,000 / admission	Not covered	Prior authorization required.
	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).
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	Professional services are included in the facility fee.
	Childbirth/delivery facility services	\$200 / day up to \$1,000 / admission	Not covered	None
If you need help recovering or have	Home health care	No charge	Not covered	130 visit limit / year. Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
other special needs	Rehabilitation services	Outpatient: \$25 / visit Inpatient: \$200 / day up to \$1,000 / admission	Not covered	Outpatient: 20 visit limit / therapy / year. Prior authorization required. Inpatient: Prior authorization required.
	Habilitation services	\$25 / visit	Not covered	20 visit limit / therapy / 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 services	No charge	Not covered	Prior authorization required.
	Children's eye exam	\$15 / visit for refractive exam	Not covered	None
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
	Children's dental checkups	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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult and Child)
- 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 (12 visit limit / year)
- Bariatric surgery
- Hearing aids (Adult: \$1,500 limit / ear / 3 years) (dependents under age 26: 1 aid / ear, every 36 months)
- Infertility treatment
- 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.

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.ccio.cms.gov
Oregon Division of Financial Regulation	1-888-877-4894 or www.dfr.oregon.gov
Washington Department of Insurance	1-800- 562- 6900 or www.insurance.wa.gov

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

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).

[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).

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 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](#) \$25
- [Hospital \(facility\) copayment](#) \$200
- [Other \(blood work\) copayment](#) \$15

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](#) \$25
- [Hospital \(facility\) copayment](#) \$200
- [Other \(blood work\) copayment](#) \$15

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

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$25
- [Hospital \(facility\) copayment](#) \$200
- [Other \(x-ray\) copayment](#) \$15

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*)

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*)

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 \$12,700

Total Example Cost \$5,600

Total Example Cost \$2,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$360

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$710

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$550

[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 on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, 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. Ste 100, Portland, OR 97232-2099, Phone: **1-800-813-2000** (TTY: **711**). 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 2020, 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/online-services/cc/pub/complaintinformation.aspx>.

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) መረጃ: የሚናገሩት ቋንቋ እያርፍ ከሆነ የትርጉም እርዳታ ድርጅቶች በገደብ የተዘጋጁታል። ወደ መከተለው ቁጥር ይደውሉ
1-800-813-2000 (TTY: 711)።

العربية (Arabic) ملحوظة: إذا كنت تكلمت بالعربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم **1-800-813-2000** (TTY: 711) .

中文 (Chinese) 注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-813-2000** (TTY: 711) 。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-813-2000** تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-813-2000** (TTY: 711).

日本語 (Japanese) 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-813-2000** (TTY: 711) まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ព័្រឹប្រឹក្សា: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាសម្រាប់អ្នកនិយាយភាសាខ្មែរ ត្រូវបានផ្តល់ឱ្យឥតគិតថ្លៃ។
ទូរស័ព្ទ **1-800-813-2000** (TTY: 711)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-813-2000 (TTY: 711) 번으로 전화해 주십시오.

ລາວ (Laotian) ປຶ້ງຄຳ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການ ບໍລິການຊ່ວຍເຫຼືອຕໍ່ພາສາ, ໄດ້ຖືກບໍລິໂພກ, ແລະມີໄວ້ອໍມ໌ໃຫ້ທ່ານ.
ໂທ **1-800-813-2000** (TTY: 711).

Afaan Oromoo (Oromo) XIYYEEFFANNA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bibilaa **1-800-813-2000** (TTY: 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਸੀਂ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੋ।
1-800-813-2000 (TTY: 711) 'ਤੇ ਆਲੋਚਨਾ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: 711).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: 711).

Español (Spanish) ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (TTY: 711).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: 711).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: 711).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-813-2000** (TTY: 711).