

Your medical benefits

Kaiser Permanente Access PPO

ID cards

Approximately 10-14 business days after your effective date, you will receive your Kaiser ID cards. Your cards include information that your providers will need to bill your insurance.

If you need your ID card information prior to receiving them, contact AWC Trust staff at benefitinfo@awcnet.org.

Provider network

To find a Kaiser Permanente provider, go to their website at www.kaiserpermanente.org, under *Find a doctor or medical facility*. Choose "Access PPO" as your provider network to find Kaiser Foundation Health Plan of WA contracted providers. Additionally, First Choice Health Network, First Health Network and MedImpact pharmacies are all in-network preferred providers.

You are eligible for covered services from within the Kaiser preferred provider network, as well as any licensed provider, medical center, or hospital in the U.S. outside of this network. When you see a Kaiser network preferred provider, you will have the least out-of-pocket expenses.

Prescription coverage

All drugs, supplies and devices must be obtained by a Kaiser designated pharmacy or in-network provider. Preferred generic drugs, preferred brand name drugs, and non-preferred generic and brand name drugs are covered at the applicable copays/cost-share, available in a 30-day supply. Generic drugs are dispensed whenever available. Mail order drugs are available through the Kaiser designated mail order service, up to a 90-day supply. Some prescriptions require pre-authorization.

Open enrollment

Open enrollment happens each year, with changes effective on **January 1**.

To make changes, you will need to complete an AWC Combined Insurance Enrollment Form and return it to your employer.

Qualifying events (child birth, marriage, etc.) allow you to add dependents outside of open enrollment.

Dependent verification

Proof of dependency is required following the enrollment of dependents. Documentation required includes (but is not limited to) marriage certificate, affidavit of marriage/domestic partnership, joint ownership documents, birth certificate, adoption papers.

A request for dependent eligibility documentation will arrive via US mail after your insurance paperwork has been processed.



Questions?


For questions about your medical plan, when your medical benefits begin, providers covered by your medical plan, or your ID card status, check with your employer's human resources department or contact **AWC Trust staff at 1-800-562-8981**.

You can also contact **Kaiser Permanente customer service at 1-888-901-4636**.



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 ? | <u>Preferred provider</u> : \$250 Individual / \$750 Family Shared with <u>preferred provider</u> and <u>out-of-network provider networks</u> | 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 ? | <u>Preferred provider</u> : \$2,500 Individual / \$5,000 Family Shared with <u>preferred provider</u> and <u>out-of-network provider networks</u> | 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 ? | <u>Premiums</u> , <u>balance-billing</u> 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 1-888-901-4636 (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 ? | No. | You can see the specialist you choose without a referral . |

 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 |
|---|--|---|--|---|
| | | Preferred 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 | \$10 / visit(\$5 enhanced benefit), deductible does not apply. | \$10 / visit, then 30% coinsurance | None |
| | Specialist visit | \$20 (\$10 enhanced benefit) / visit, deductible does not apply. | \$20 / visit, then 30% coinsurance | None |
| | Preventive care/screening/immunization | No charge , deductible does not apply. | 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) | 10% coinsurance | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | Preauthorization required |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary | Preferred generic drugs | \$10 (retail); 2x retail cost share (mail order) / prescription , deductible does not apply. | Not covered | Up to a 30-day supply (retail); up to a 90-day supply (mail order). No charge for contraceptives. Subject to formulary guidelines. |
| | Preferred brand drugs | \$35 or (\$30 enhanced) (retail); 2x retail cost share (mail order) / prescription , deductible does not apply. | Not covered | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. |
| | Non-preferred drugs | \$70 or (\$65 enhanced) (retail); 2x retail cost share (mail order) / prescription , deductible does not apply. | Not covered | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. |
| | Specialty drugs | Applicable Preferred generic, Preferred brand or Non-Preferred cost shares apply | Not covered | Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process. |
| If you have | Facility fee (e.g., | 10% coinsurance | 30% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| outpatient surgery | ambulatory surgery center) | | | |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | None |
| If you need immediate medical attention | Emergency room care | \$150 / visit, then 10% coinsurance | \$150 / visit, then 10% 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 | 10% coinsurance | 10% coinsurance | None |
| | Urgent care | \$10 / visit(\$5 enhanced benefit), deductible does not apply. | \$10 / visit, then 30% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | You must notify Kaiser Permanente of admission or will not be covered. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | You must notify Kaiser Permanente of admission or will not be covered. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$10 / visit(\$5 enhanced benefit), deductible does not apply. | \$10 / visit, then 30% coinsurance | None |
| | Inpatient services | 10% coinsurance | 30% coinsurance | You must notify Kaiser Permanente of admission or will not be covered. |
| If you are pregnant | Office visits | 10% coinsurance | 30% coinsurance | 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 | 10% coinsurance | 30% 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 | 10% coinsurance | 30% 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 | Home health care | 10% coinsurance | 30% coinsurance | You must notify Kaiser Permanente or will not |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|--|---|
| | | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| recovering or have other special health needs | | | | be covered. |
| | Rehabilitation services | Outpatient: \$20 (\$10 enhanced benefit) / visit , deductible does not apply. Inpatient: 10% coinsurance | Outpatient: \$20 / visit, then 30% coinsurance Inpatient: 30% 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 preferred and out-of-network provider networks . |
| | Habilitation services | Outpatient: \$20 (\$10 enhanced benefit) / visit , deductible does not apply. Inpatient: 10% coinsurance | Outpatient: \$20 / visit, then 30% coinsurance Inpatient: 30% 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 preferred and out-of-network provider networks . |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | 60 -day limit / year. Limits are combined with preferred and Out-of-Network Provider networks . You must notify Kaiser Permanente of admission or will not be covered. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | Subject to formulary guidelines. Preauthorization may be required |
| | Hospice services | 10% coinsurance | 30% coinsurance | You must notify Kaiser Permanente of admission or will not be covered. |
| If your child needs dental or eye care | Children's eye exam | No charge for refractive exam, deductible does not apply. | No charge for refractive exam, deductible does not apply. | 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 | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult and child) | • Private-duty nursing | |

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

- | | | |
|---------------------------------------|---|--|
| • Acupuncture (20 visit limit / year) | • Chiropractic care (20 visit limit / year) | • Infertility treatment (\$20,000 medical limit; |
|---------------------------------------|---|--|

- Bariatric surgery (\$35,000 limit / lifetime)
- Hearing aids (1 aid / ear / 36 months)
- \$5,000 drug limit / lifetime)
- 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 |
| 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).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-901-4636 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-901-4636 (TTY: 711).

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-888-901-4636 (TTY: 711) uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-901-4636 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-901-4636 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 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 | \$250 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other (blood work) coinsurance | 10% |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$250 |
| Copayments | \$10 |
| Coinsurance | \$1,100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Peg would pay is | \$1,380 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$250 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other (blood work) coinsurance | 10% |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$40 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$740 |

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$250 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other (x-ray) coinsurance | 10% |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$250 |
| Copayments | \$200 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$650 |

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