

> CORE AND ACCESS PPO PLAN OPTIONS



# 2019 HIHIT plans

## Keep your employees, and your bottom line, healthy

At Kaiser Permanente, our goal is to provide exceptional health care to your employees while helping you manage your health care costs. We offer a range of plans that are reasonably priced. And our doctors, pharmacies, and lab services all work together, usually under one roof, to provide high-quality, cost-effective care.

With a 24-hour consulting nurse helpline, care management programs, and convenient online services, we make it easy for your employees to take better care of their health.



Healthier employees mean a healthier balance sheet.

Questions? Please contact  
HIHIT at 877-892-9203

## 3 types of plans: What's the difference?

Kaiser Permanente offers HIHIT members 3 types of plans, each with their own strengths: Core plans, Access PPO plans, and our HSA plan. All plans give your employees access to Kaiser Permanente doctors, the top-ranked medical group in the state.<sup>1</sup>

### 1 CORE PLANS

Our Core network offers employees access to specially selected providers within the Kaiser Permanente network. Choosing these plans gives employers and employees our greatest value.

- More than 1,100 providers at Kaiser Permanente medical offices (31 locations)<sup>2</sup>
- Our most cost-effective care
- More than 9,000 additional providers in Washington who contract directly with us.<sup>3</sup> We work closely with these providers to improve patient care so they meet our high standards of care and service

### 2 ACCESS PPO PLANS

For employees who are willing to pay more in premiums for a broader selection of providers, there are 6 Access PPO plans to choose from. They're the only PPO plans that feature access to our high-performing health system at Kaiser Permanente medical offices.<sup>4</sup>

- More than 1,100 providers at Kaiser Permanente medical offices (31 locations)<sup>2</sup>
- 9,000 additional providers in Washington who contract directly with Kaiser Permanente<sup>3</sup>
- 75,000 providers with the regional First Choice Health network in the Pacific Northwest
- More than a million health care professionals in all other states through the First Health network

With an Access PPO plan, your employees can take advantage of reduced cost shares by choosing care from Kaiser Permanente doctors and select Washington providers in our service areas. In the plan summaries that follow, the lower costs are noted under the provider column as "enhanced benefit."

### 3 CORE HSA PLAN

This option offers the benefits of our Core plan and allows employers and employees to make monetary contributions to a health savings account (HSA). This money is tax-free and can be applied to the costs of health care services.

#### Cost-effective care

Provide your employees the best care possible and keep company health care costs in line. When your employees seek care from Kaiser Permanente providers, they'll be taking advantage of our most cost-effective care. This helps to keep costs down for you and your employees. Plus, Kaiser Permanente doctors are the top-ranked medical group in Washington.<sup>1</sup>

<sup>1</sup>Washington Health Alliance, 2017 Community Checkup [www.wacommunitycheckup.org](http://www.wacommunitycheckup.org); Ranking applies to Kaiser Permanente Washington's medical group, Washington Permanente Medical Group, P.C.

<sup>2</sup>Washington Permanente Medical Group December, 2017.

<sup>3</sup>OIC Provider Network Form A.

<sup>4</sup>Criteria established by American Medical Group Association.

## Choosing the right plans for your employees

As a member of HIHIT, you can choose from 11 Kaiser Permanente plans this year – 4 Core plans, 6 Access PPO plans, and 1 HSA plan.

Our plans are designed to serve different needs, so they vary in monthly premiums and cost shares (deductibles, copays, and coinsurance). Choose plans that take into account the health care needs of your workforce – and that offer a good balance between monthly premiums and the cost of care.



**Each plan offers services designed to help keep your employees feeling their best:**

- Preventive care covered in full
- Medical advice via our 24/7 consulting nurse helpline
- Online prescription refills
- Care managers for complex health issues
- Walk-in CareClinic by Kaiser Permanente at 15 Bartell Drugs locations
- Online visits for quick diagnosis and treatment

### Core plans: Least to most expensive

▶ **Topaz** – See plan details on page 6

▶ **Pearl** – See plan details on page 7

▶ **Onyx** – See plan details on page 8

▶ **HSA** – See plan details on page 9

▶ **Jade** – See plan details on page 10

Click the ▶ to jump to that plan's page.

### Core plan highlights

**Topaz:** Our lowest cost plan for employers looking to provide basic coverage for employees. All services subject to the \$5,000 deductible with the exception of prescriptions, which are covered with just copays. Preventive care is covered in full.

**Pearl:** All services subject to the \$2,500 deductible with the exception of prescriptions, which are covered with just copays.

**Onyx:** With Onyx, employees have upfront coverage – the first 4 office visits per member and prescriptions are covered with copays, and the first \$500 in labs/X-rays is covered in full. This helps keep the average user from ever meeting their \$5,000 deductible.

**HSA:** High Deductible Health Plan that employers/employees are eligible to pair with a health savings account to take advantage of IRS tax savings rules. All services, including prescriptions, subject to the deductible.

**Jade:** Provides upfront coverage for the average user. The first 4 office visits per member and prescriptions are covered with copays, and the first \$500 in labs/X-rays is covered in full.

## PPO plans: Least to most expensive

- ▶ **Opal** – See plan details on page 11
- ▶ **Ruby** – See plan details on page 12
- ▶ **Quartz** – See plan details on page 13
- ▶ **Sapphire** – See plan details on page 14
- ▶ **Emerald** – See plan details on page 15
- ▶ **Diamond** – See plan details on page 16

Click the ▶ to jump to that plan’s page.

### PPO plan highlights

**Opal:** Lowest-cost PPO plan for employers looking to provide basic coverage for employees. All services subject to the \$5,000 deductible with the exception of prescriptions, which are covered with just copays. Preventive care is covered in full.

**Ruby:** HITH’s most popular plan with good coverage in an affordable price range. All office visits and prescriptions are covered with just copays. Deductible is \$3,000, which allows the premium to be lower.

**Quartz:** Provides upfront coverage for the average user. The first 4 office visits per member and prescriptions are covered with copays, and the first \$500 in labs/X-rays is covered in full.

**Sapphire:** Provides upfront coverage for the average user. The first 4 office visits per member and prescriptions are covered with copays, and the first \$500 in labs/X-rays is covered in full.

**Emerald:** Provides great coverage although at a lesser cost than Diamond. Deductible is slightly higher than Diamond. Provides coverage for the average user with the first 4 office visits per member and prescriptions covered with copays and the first \$500 in labs/X-rays covered is covered in full.

**Diamond:** For employers looking to offer employees our most robust coverage. Low deductible. Office visits and prescriptions are covered with copays.



### Family and spousal options

All plans are offered for employees and their families, including spouses.

Our Ruby plan is also available for employees and their children without spousal coverage.

# Topaz plan

## CORE PLAN NETWORK

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 44 hospitals<sup>2</sup>

## VALUE-BASED BENEFITS

Preventive care services are covered in full.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington.

PCY = Per calendar year.

## 2019 CORE TOPAZ PLAN

COVERAGE	PREFERRED PROVIDER
<b>Annual deductible</b> What the member pays before the plan pays. ♦ = Deductible does not apply to these services.	\$5,000 per individual / \$10,000 per family
<b>Coinsurance</b> What the member pays	50%
<b>Annual out-of-pocket limit</b>	\$7,150 per individual / \$14,300 per family
BENEFITS	After deductible, member pays
<b>Office visits</b>	\$40 copay per visit + 50%
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ♦, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full.♦
<b>Manipulative therapy</b> 10 self-referred visits PCY	\$40 copay per visit + 50%
<b>Naturopathy</b> 3 self-referred visits PCY, per medical diagnosis	\$40 copay per visit + 50%
<b>Acupuncture</b> 12 self-referred visits PCY	\$40 copay per visit + 50%
<b>Outpatient maternity care</b> Routine care not subject to copay	\$40 copay per visit + 50%
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$40 copay per visit + 50%
<b>Outpatient mental health</b>	\$40 copay per visit + 50%
<b>Outpatient lab/radiology</b>	Deductible and coinsurance apply
<b>Emergency care</b> Copay waived if admitted	\$200 copay + 50%
<b>Hospital – inpatient</b>	\$1,000 copay per admit ♦, then deductible and coinsurance apply
<b>Ambulance</b>	20% ♦
<b>Prescription drugs</b> Preferred generic/preferred brand	\$20/\$40 ♦ Mail order: pay 2 copays per 90-day supply ♦
<b>Routine vision exam</b> 1 visit per 12 months	\$40 copay ♦
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered

# Pearl plan

## CORE PLAN NETWORK

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 44 hospitals<sup>2</sup>

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington.

PCY = Per calendar year.

## 2019 CORE PEARL PLAN

COVERAGE	PREFERRED PROVIDER
<b>Annual deductible</b> What the member pays before the plan pays. ♦ = Deductible does not apply to these services.	\$2,500 per individual / \$5,000 per family
<b>Coinsurance</b> What the member pays	30%
<b>Annual out-of-pocket limit</b>	\$7,150 per individual / \$14,300 per family
BENEFITS	After deductible, member pays
<b>Office visits</b>	\$40 copay + 30% per visit
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ♦, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full.♦
<b>Manipulative therapy</b> 10 self-referred visits PCY	\$40 copay + 30% per visit
<b>Naturopathy</b> 3 self-referred visits PCY, per medical diagnosis	\$40 copay + 30% per visit
<b>Acupuncture</b> 12 self-referred visits PCY	\$40 copay + 30% per visit
<b>Outpatient maternity care</b> Routine care not subject to copay	\$40 copay + 30% per visit
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$40 copay + 30% per visit
<b>Outpatient mental health</b>	\$40 copay + 30% per visit
<b>Outpatient lab/radiology</b>	Deductible and coinsurance apply
<b>Emergency care</b> Copay waived if admitted	\$200 copay + 30%
<b>Hospital – inpatient</b>	30%
<b>Ambulance</b>	30%
<b>Prescription drugs</b> Preferred generic/preferred brand/nonpreferred	\$25/\$50/\$75 ♦ Mail order: pay 2 copays per 90-day supply ♦
<b>Routine vision exam</b> 1 visit per 12 months	\$40 copay ♦
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered

# Onyx plan

## CORE PLAN NETWORK

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 44 hospitals<sup>2</sup>

## VALUE-BASED BENEFITS

Preventive care services are covered in full. Plus your first 4 office visits per year are not subject to deductible or coinsurance. Your first \$500 per year in outpatient lab and radiology is covered in full. Then deductible and coinsurance apply.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington.

PCY = Per calendar year.

## 2019 CORE ONYX PLAN

COVERAGE	PREFERRED PROVIDER
<b>Annual deductible</b> What the member pays before the plan pays. ♦ = Deductible does not apply to these services.	\$5,000 per individual / \$10,000 per family
<b>Coinsurance</b> What the member pays	30%
<b>Annual out-of-pocket limit</b>	\$7,150 per individual / \$14,300 per family
BENEFITS	After deductible, member pays
<b>Office visits</b>	Primary \$25 copay per visit + 30% Specialty \$50 copay per visit +30% First 4 visits PCY not subject to deductible or coinsurance ♦
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ♦, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full.♦
<b>Manipulative therapy</b> 10 self-referred visits PCY	\$25 copay per visit + 30%
<b>Naturopathy</b> 3 self-referred visits PCY, per medical diagnosis	\$25 copay per visit + 30%
<b>Acupuncture</b> 12 self-referred visits PCY	\$25 copay per visit + 30%
<b>Outpatient maternity care</b> Routine care not subject to copay	\$25 copay per visit + 30%
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$25 copay per visit + 30%
<b>Outpatient mental health</b>	\$25 copay per visit + 30%
<b>Outpatient lab/radiology</b>	First \$500 per year covered in full ♦, then deductible and coinsurance apply
<b>Emergency care</b> Copay waived if admitted	\$200 copay + 30%
<b>Hospital – inpatient</b>	30%
<b>Ambulance</b>	20% ♦
<b>Prescription drugs</b> Preferred generic/preferred brand	\$25/\$50 ♦ Mail order: pay 2 copays per 90-day supply ♦
<b>Routine vision exam</b> 1 visit per 12 months	\$25 copay ♦
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered

# HSA plan

## CORE PLAN NETWORK

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 44 hospitals<sup>2</sup>

## VALUE-BASED BENEFITS

Preventive care services are covered in full. Certain preventive medications are covered in full.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington.

PCY = Per calendar year.

## 2019 CORE HSA PLAN

COVERAGE	PREFERRED PROVIDER
<b>Annual deductible</b> What the member pays before the plan pays. Until the total family annual deductible is met, benefits will not be provided for any family member. ♦ = Deductible does not apply to these services.	\$2,500 per individual / \$5,000 per family
<b>Coinsurance</b> What the member pays	80%
<b>Annual out-of-pocket limit</b>	\$4,500 per individual / \$7,150 per family
BENEFITS	
After deductible, member pays	
<b>Office visits</b>	80%
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ♦, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full. ♦
<b>Manipulative therapy</b> 10 self-referred visits PCY	80%
<b>Naturopathy</b> 3 self-referred visits PCY, per medical diagnosis	80%
<b>Acupuncture</b> 12 self-referred visits PCY	80%
<b>Outpatient maternity care</b> Routine care not subject to copay	80%
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	80%
<b>Outpatient mental health</b>	80%
<b>Outpatient lab/radiology</b>	Deductible and coinsurance apply
<b>Emergency care</b> Copay waived if admitted	Deductible and coinsurance apply
<b>Hospital – inpatient</b>	80%
<b>Ambulance</b>	80%
<b>Prescription drugs</b> Preferred generic/preferred brand/nonpreferred	\$20/\$40/\$60 deductible applies Mail order: pay 3 copays per 90 day supply
<b>Routine vision exam</b> 1 visit per 12 months	Deductible and coinsurance apply
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered

# Jade plan

## CORE PLAN NETWORK

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 44 hospitals<sup>2</sup>

## VALUE-BASED BENEFITS

Preventive care services are covered in full. Plus your first 4 office visits per year are not subject to deductible or coinsurance. Your first \$500 per year in outpatient lab and radiology is covered in full. Then deductible and coinsurance apply.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington.

PCY = Per calendar year.

## 2019 CORE JADE PLAN

COVERAGE	PREFERRED PROVIDER
<b>Annual deductible</b> What the member pays before the plan pays. ♦ = Deductible does not apply to these services.	\$2,500 per individual / \$5,000 per family
<b>Coinsurance</b> What the member pays	20%
<b>Annual out-of-pocket limit</b>	\$7,150 per individual / \$14,300 per family
BENEFITS	
After deductible, member pays	
<b>Office visits</b>	Primary \$25 copay per visit + 20% Specialty \$50 copay per visit +20% First 4 visits PCY not subject to deductible or coinsurance ♦
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ♦, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full.♦
<b>Manipulative therapy</b> 10 self-referred visits PCY	\$25 copay per visit + 20%
<b>Naturopathy</b> 3 self-referred visits PCY, per medical diagnosis	\$25 copay per visit + 20%
<b>Acupuncture</b> 12 self-referred visits PCY	\$25 copay per visit + 20%
<b>Outpatient maternity care</b> Routine care not subject to copay	\$25 copay per visit + 20%
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$25 copay per visit + 20%
<b>Outpatient mental health</b>	\$25 copay per visit + 20%
<b>Outpatient lab/radiology</b>	First \$500 per year covered in full ♦, then deductible and coinsurance apply
<b>Emergency care</b> Copay waived if admitted	\$200 copay + 20%
<b>Hospital – inpatient</b>	20%
<b>Ambulance</b>	20% ♦
<b>Prescription drugs</b> Preferred generic/preferred brand	\$25/\$50 ♦ Mail order: pay 2 copays per 90-day supply ♦
<b>Routine vision exam</b> 1 visit per 12 months	\$25 copay ♦
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered

# Opal plan

## ACCESS PPO PROVIDER NETWORK

### In network

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 75,000 providers with regional First Choice Health
- 1 million plus national providers with First Health network

### Out of network

- Any licensed provider in the United States

## ENHANCED BENEFITS

Select providers – including Kaiser Permanente doctors – are available with reduced cost shares.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.

PCY = Per calendar year.

## 2019 ACCESS PPO OPAL PLAN

COVERAGE	PREFERRED PROVIDER	OUT OF NETWORK
<b>Annual deductible</b> What the member pays before the plan pays. ♦ = Deductible does not apply to these services.	\$5,000 per individual / \$10,000 per family	\$10,000 per individual / \$20,000 per family
<b>Coinsurance</b> What the member pays	50%	50%
<b>Annual out-of-pocket limit</b>	\$7,150 per individual / \$14,300 per family	\$14,300 per individual / \$28,600 per family
BENEFITS		
After deductible, member pays		
<b>Office visits</b>	\$25 copay + 50% per visit (\$15 copay + 50% enhanced benefit)	50%
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ♦, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full.♦	50% Routine mammograms: 50% Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are subject to the applicable preventive care cost share and benefit maximums.
<b>Manipulative therapy</b> 12 self-referred visits PCY	\$25 copay + 50% per visit	50%
<b>Naturopathy</b>	\$25 copay + 50% per visit	50%
<b>Acupuncture</b> 8 self-referred visits PCY	\$25 copay + 50% per visit	50%
<b>Outpatient maternity care</b> Routine care not subject to copay	\$25 copay + 50% per visit (\$15 copay + 50% enhanced benefit)	50%
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$25 copay + 50% per visit (\$15 copay + 50% enhanced benefit)	50%
<b>Outpatient mental health</b>	\$25 copay + 50% per visit (\$15 copay + 50% enhanced benefit)	50%
<b>Outpatient lab/radiology</b>	50%	50%
<b>Emergency care</b> Copay waived if admitted	\$250 copay + 50%	\$250 copay + 50%
<b>Hospital – inpatient</b>	50%	50%
<b>Ambulance</b>	50%	50%
<b>Prescription drugs</b> Preferred generic/preferred brand/nonpreferred	\$20/\$50/\$95 (\$15/\$45/\$85 at Kaiser Permanente pharmacies in our service area ♦) Mail order: pay 2 copays per 90-day supply ♦	Not covered
<b>Routine vision exam</b> 1 visit per 12 months	Covered in full ♦	Covered in full ♦
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered	Not covered

# Ruby plan

## ACCESS PPO PROVIDER NETWORK

### In network

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 75,000 providers with regional First Choice Health
- More than 1 million national providers with First Health network

### Out of network

- Any licensed provider in the United States

## ENHANCED BENEFITS

Select providers – including Kaiser Permanente doctors – are available with reduced cost shares.

## VALUE-BASED BENEFITS

Office visits with preferred providers are not subject to deductible or coinsurance – you just pay a copay.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.

PCY = Per calendar year.

## 2019 ACCESS PPO RUBY PLAN

COVERAGE	PREFERRED PROVIDER	OUT OF NETWORK
<b>Annual deductible</b> What the member pays before the plan pays. ◆ = Deductible does not apply to these services.	\$3,000 per individual / \$6,000 per family	\$6,000 per individual / \$12,000 per family
<b>Coinsurance</b> What the member pays	30%	50%
<b>Annual out-of-pocket limit</b>	\$7,150 per individual / \$14,300 per family	\$14,300 per individual / \$28,600 per family
BENEFITS		
After deductible, member pays		
<b>Office visits</b>	\$40 copay per visit (\$30 copay enhanced benefit) ◆	50%
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ◆, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full.◆	50% Routine mammograms: 50% Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are subject to the applicable preventive care cost share and benefit maximums.
<b>Manipulative therapy</b> 8 self-referred visits PCY	\$40 copay per visit ◆	50%
<b>Naturopathy</b>	\$40 copay per visit ◆	50%
<b>Acupuncture</b> 12 self-referred visits PCY	\$40 copay per visit ◆	50%
<b>Outpatient maternity care</b> Routine care not subject to copay	\$40 copay per visit ◆ (\$30 copay enhanced benefit) ◆	50%
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$40 copay per visit ◆ (\$30 copay enhanced benefit) ◆	50%
<b>Outpatient mental health</b>	\$40 copay per visit ◆ (\$30 copay enhanced benefit) ◆	50%
<b>Outpatient lab/radiology</b>	30%	50%
<b>Emergency care</b> Copay waived if admitted	\$250 copay + 30%	\$250 copay + 30%
<b>Hospital – inpatient</b>	30%	50%
<b>Ambulance</b>	30%	30%
<b>Prescription drugs</b> Preferred generic/preferred brand/nonpreferred	\$20/\$50/\$95 ◆ (\$15/\$45/\$85 at Kaiser Permanente pharmacies in our service area ◆) Mail order: pay 2 copays per 90-day supply ◆	Not covered
<b>Routine vision exam</b> 1 visit per 12 months	Covered in full ◆	Covered in full ◆
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered	Not covered

# Quartz plan

## ACCESS PPO PROVIDER NETWORK

### In network

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 75,000 providers with regional First Choice Health
- 1 million plus national providers with First Health network

### Out of network

- Any licensed provider in the United States

## ENHANCED BENEFITS

Select providers – including Kaiser Permanente doctors – are available with reduced cost shares. Preventive care services are covered in full. Plus your first 4 office visits per year are not subject to deductible or coinsurance. Your first \$500 per year in outpatient lab and radiology is covered in full. Then deductible and coinsurance apply.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.

PCY = Per calendar year.

## 2019 ACCESS PPO QUARTZ PLAN

COVERAGE	PREFERRED PROVIDER	OUT OF NETWORK
<b>Annual deductible</b> What the member pays before the plan pays. ◆ = Deductible does not apply to these services.	\$2,500 per individual / \$5,000 per family	\$5,000 per individual / \$10,000 per family
<b>Coinsurance</b> What the member pays	20%	Member pays 50% of allowed amount
<b>Annual out-of-pocket limit</b>	\$7,150 per individual / \$14,300 per family	\$14,300 per individual / \$28,600 per family
BENEFITS		
After deductible, member pays		
<b>Office visits</b>	\$25 copay per visit (\$15 enhanced benefit) + 20% First 4 visits PCY not subject to deductible or coinsurance ◆	No copay; deductible and coinsurance apply
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ◆, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full.◆	Not covered Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable preventive care cost share and benefit maximums.
<b>Manipulative therapy</b> 8 self-referred visits PCY	\$25 copay + 20% per visit	No copay; deductible and coinsurance apply
<b>Naturopathy</b>	\$25 copay + 20% per visit	No copay; deductible and coinsurance apply
<b>Acupuncture</b> 12 self-referred visits PCY	\$25 copay + 20% per visit	No copay; deductible and coinsurance apply
<b>Outpatient maternity care</b> Routine care not subject to copay	\$25 copay + 20% per visit (\$15 copay + 20% enhanced benefit)	No copay; deductible and coinsurance apply
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$25 copay + 20% per visit (\$15 copay + 20% enhanced benefit)	No copay; deductible and coinsurance apply
<b>Outpatient mental health</b>	\$25 copay + 20% per visit (\$15 copay + 20% enhanced benefit)	No copay; deductible and coinsurance apply
<b>Outpatient lab/radiology</b>	Lab and X-ray services are covered in full up to \$500 per calendar year (limit shared with preferred provider and out-of-network provider), then deductible and coinsurance apply. ◆	
<b>Emergency care</b> Copay waived if admitted	\$200 copay + 20%	\$200 copay + 20%
<b>Hospital – inpatient</b>	\$200 copay, per admit Deductible and coinsurance apply	\$200 copay, per admit Deductible and coinsurance apply
<b>Ambulance</b>	20%	Preferred provider deductible and coinsurance apply
<b>Prescription drugs</b> Preferred generic/preferred brand/nonpreferred	\$20/\$50/\$95 (\$15/\$45/\$85 at Kaiser Permanente pharmacies ◆). Mail order: pay 2 copays per 90-day supply ◆	Not covered
<b>Routine vision exam</b> 1 visit per 12 months	Covered in full ◆	Covered in full ◆
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered	Not covered

# Sapphire plan

## ACCESS PPO PROVIDER NETWORK

### In network

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 75,000 providers with regional First Choice Health
- More than 1 million national providers with First Health network

### Out of network

- Any licensed provider in the United States

## ENHANCED BENEFITS

Select providers – including Kaiser Permanente doctors – are available with reduced cost shares.

## VALUE-BASED BENEFITS

First 4 office visits per year with preferred providers are not subject to deductible or coinsurance – you just pay a copay.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.

PCY = Per calendar year.

## 2019 ACCESS PPO SAPPHIRE PLAN

COVERAGE	PREFERRED PROVIDER	OUT OF NETWORK
<b>Annual deductible</b> What the member pays before the plan pays. ◆ = Deductible does not apply to these services.	\$1,500 per individual / \$4,500 per family	\$3,000 per individual / \$9,000 per family
<b>Coinsurance</b> What the member pays	20%	50%
<b>Annual out-of-pocket limit</b>	\$4,000 per individual / \$12,000 per family	\$8,000 per individual / \$24,000 per family
BENEFITS		
After deductible, member pays		
<b>Office visits</b>	\$40 copay + 20% per visit (\$30 copay + 20% enhanced benefit). First 4 visits PCY not subject to deductible or coinsurance ◆	50%
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ◆, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full.◆	50% Routine mammograms: 50% Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are subject to the applicable preventive care cost share and benefit maximums.
<b>Manipulative therapy</b> 8 self-referred visits PCY	\$40 copay + 20% per visit	50%
<b>Naturopathy</b>	\$40 copay + 20% per visit	50%
<b>Acupuncture</b> 12 self-referred visits PCY	\$40 copay + 20% per visit	50%
<b>Outpatient maternity care</b> Routine care not subject to copay	\$40 copay + 20% per visit (\$30 copay + 20% enhanced benefit)	50%
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$40 copay + 20% per visit (\$30 copay + 20% enhanced benefit)	50%
<b>Outpatient mental health</b>	\$40 copay + 20% per visit (\$30 copay + 20% enhanced benefit)	50%
<b>Outpatient lab/radiology</b>	First \$500 per year covered in full ◆, then deductible and coinsurance apply	
<b>Emergency care</b> Copay waived if admitted	\$200 copay + 20%	\$200 copay + 20%
<b>Hospital – inpatient</b>	20%	50%
<b>Ambulance</b>	20%	20%
<b>Prescription drugs</b> Preferred generic/preferred brand/nonpreferred	\$20/\$50/\$95 ◆ (\$15/\$45/\$85 at Kaiser Permanente pharmacies in our service area ◆) Mail order: pay 2 copays per 90-day supply ◆	Not covered
<b>Routine vision exam</b> 1 visit per 12 months	Covered in full ◆	Covered in full ◆
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered	Not covered

# Emerald plan

## ACCESS PPO PROVIDER NETWORK

### In network

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 75,000 providers with regional First Choice Health
- More than 1 million national providers with First Health network

### Out of network

- Any licensed provider in the United States

## ENHANCED BENEFITS

Select providers – including Kaiser Permanente doctors – are available with reduced cost shares.

## VALUE-BASED BENEFITS

First 4 office visits per year with preferred providers are not subject to deductible or coinsurance – you just pay a copay.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.

PCY = Per calendar year.

## 2019 ACCESS PPO EMERALD PLAN

COVERAGE	PREFERRED PROVIDER	OUT OF NETWORK
<b>Annual deductible</b> What the member pays before the plan pays. ◆ = Deductible does not apply to these services.	\$1,000 per individual / \$2,000 per family	\$2,000 per individual / \$4,000 per family
<b>Coinsurance</b> What the member pays	20%	40%
<b>Annual out-of-pocket limit</b>	\$5,000 per individual / \$10,000 per family	\$10,000 per individual / \$20,000 per family
BENEFITS		
After deductible, member pays		
<b>Office visits</b>	\$25 copay + 20% per visit (\$15 copay + 20% enhanced benefit). First 4 visits PCY not subject to deductible or coinsurance ◆	40%
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ◆, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full. ◆	40% Routine mammograms: 40% Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are subject to the applicable preventive care cost share and benefit maximums.
<b>Manipulative therapy</b> 8 self-referred visits PCY	\$25 copay + 20% per visit	40%
<b>Naturopathy</b>	\$25 copay + 20% per visit	40%
<b>Acupuncture</b> 12 self-referred visits PCY	\$25 copay + 20% per visit	40%
<b>Outpatient maternity care</b> Routine care not subject to copay	\$25 copay + 20% per visit (\$15 copay + 20% enhanced benefit)	40%
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$25 copay + 20% per visit (\$15 copay + 20% enhanced benefit)	40%
<b>Outpatient mental health</b>	\$25 copay + 20% per visit (\$15 copay + 20% enhanced benefit)	40%
<b>Outpatient lab/radiology</b>	First \$500 per year covered in full ◆ for preferred provider and out-of-network combined, then deductible and coinsurance apply	
<b>Emergency care</b> Copay waived if admitted	\$200 copay + 20%	\$200 copay + 20%
<b>Hospital – inpatient</b>	20%	40%
<b>Ambulance</b>	20%	20%
<b>Prescription drugs</b> Preferred generic/preferred brand/nonpreferred	\$20/\$50/\$95 ◆ (\$15/\$45/\$85 at Kaiser Permanente pharmacies in our service area ◆) Mail order: pay 2 copays per 90-day supply ◆	Not covered
<b>Routine vision exam</b> 1 visit per 12 months	Covered in full ◆	Covered in full ◆
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered	Not covered

# Diamond plan

## ACCESS PPO PROVIDER NETWORK

### In network

- 1,100 Kaiser Permanente providers<sup>1</sup>
- 9,000 additional contracted providers in Washington<sup>2</sup>
- 75,000 providers with regional First Choice Health
- More than 1 million national providers with First Health network

### Out of network

- Any licensed provider in the United States

## ENHANCED BENEFITS

Select providers – including Kaiser Permanente doctors – are available with reduced cost shares.

## VALUE-BASED BENEFITS

Office visits with preferred providers are not subject to deductible or coinsurance – you just pay a copay.

<sup>1</sup> Washington Permanente Medical Group December, 2017.

<sup>2</sup> OIC Provider Network Form A.

This plan also covers treatment for work-related injuries for owners/partners who are not covered by workers' compensation.

There is no fourth-quarter deductible carryover.

Unlimited lifetime benefit maximum applies to all plans.

This plan is nongrandfathered.

This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other stipulations apply.

Plan offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.

PCY = Per calendar year.

## 2019 ACCESS PPO DIAMOND PLAN

COVERAGE	PREFERRED PROVIDER	OUT OF NETWORK
<b>Annual deductible</b> What the member pays before the plan pays. ◆ = Deductible does not apply to these services.	\$500 per individual / \$1,000 per family	\$1,000 per individual / \$2,000 per family
<b>Coinsurance</b> What the member pays	20%	50%
<b>Annual out-of-pocket limit</b>	\$5,000 per individual / \$10,000 per family	\$10,000 per individual / \$20,000 per family
BENEFITS		
After deductible, member pays		
<b>Office visits</b>	\$25 copay per visit ◆ (\$15 copay enhanced benefit) ◆	50%
<b>Preventive care</b> For children and adults, including physicals and immunizations	Covered in full ◆, as established in Kaiser Permanente's preventive care schedule. Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are covered in full. ◆	50% Routine mammograms: 50% Women's preventive care services (including formulary contraceptive drugs and devices and sterilization) are subject to the applicable preventive care cost share and benefit maximums.
<b>Manipulative therapy</b> 8 self-referred visits PCY	\$25 copay per visit ◆	50%
<b>Naturopathy</b>	\$25 copay per visit ◆	50%
<b>Acupuncture</b> 12 self-referred visits PCY	\$25 copay per visit ◆	50%
<b>Outpatient maternity care</b> Routine care not subject to copay	\$25 copay per visit ◆ (\$15 copay enhanced benefit) ◆	50%
<b>Outpatient rehabilitation services</b> 45 visits combined PCY physical, speech, occupational therapy	\$25 copay per visit ◆ (\$15 copay enhanced benefit) ◆	50%
<b>Outpatient mental health</b>	\$25 copay per visit ◆ (\$15 copay enhanced benefit) ◆	50%
<b>Outpatient lab/radiology</b>	20%	50%
<b>Emergency care</b> Copay waived if admitted	\$200 copay + 20%	\$200 copay + 20%
<b>Hospital – inpatient</b>	\$200 per admission + 20%	\$200 per admission + 50%
<b>Ambulance</b>	20%	20%
<b>Prescription drugs</b> Preferred generic/preferred brand/nonpreferred	\$20/\$50/\$95 ◆ (\$15/\$45/\$85 at Kaiser Permanente pharmacies in our service area ◆) Mail order: pay 2 copays per 90-day supply ◆	Not covered
<b>Routine vision exam</b> 1 visit per 12 months	Covered in full ◆	Covered in full ◆
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered	Not covered

# Glossary

## **Coinsurance**

This is the percentage of the cost you will pay for the care you receive. You'll notice that the coinsurance levels differ among all of the plans.

## **Copayment**

This is a fixed dollar amount that you pay for a covered service or prescription.

## **Deductible**

This is what you'll pay before the plan pays for covered services. All of our plans have a deductible, but in many cases the deductible does not apply to certain services.

## **Enhanced benefit**

These are office visit copays that will be less at Kaiser Permanente medical facilities in our service area and hundreds of other select providers. You can find a list of which providers in our provider directory. Prescription copays at our pharmacies and through our mail order may also be lower.

## **Inpatient care**

This is care you get in person that requires you to stay overnight in a hospital. It could be for a physical or mental ailment.

## **Nongrandfathered plan**

This is a plan that is open to all new enrollment and is subject to certain plan benefit mandates and other requirements under the Patient Protection and Affordable Care Act.

## **Out of network**

All Access PPO plans offered here have an out-of-network benefit level. You can save money and time by choosing in-network providers. You'll pay lower out-of-pocket costs, and there are no claim forms to submit for reimbursement.

## **Out-of-pocket limit**

The most you'll be required to pay for covered services in a calendar year. Deductible, coinsurance, and copays count toward the limit. Notice that each plan has different limits.

## **Outpatient care**

This is care you get in person that doesn't require you to stay in a hospital. It could be a visit to see your personal physician, an acupuncturist, or even a specialist.

# Kaiser Permanente Nondiscrimination Notice and Language Access Services



## KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

Provide free aids and services to people with disabilities to help ensure effective communication, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats)
- Assistive devices (magnifiers, Pocket Talkers, and other aids)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance. Please call us if you need help submitting a grievance. The Civil Rights Coordinator will be notified of all grievances related to discrimination.

### Kaiser Permanente

Phone: 206-630-4636

Toll-free: 1-888-901-4636

TTY Washington Relay Service: 1-800-833-6388 or 711

TTY Idaho Relay Service: 1-800-377-3529 or 711

Electronically: [kp.org/wa/feedback](http://kp.org/wa/feedback)

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

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

**LANGUAGE ACCESS SERVICES**

**English: ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

**Español (Spanish): ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 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 1-888-901-4636 (TTY: 1-800-833-6388 / 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 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

**한국어(Korean): 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

**Русский (Russian): ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

**Filipino (Tagalog): PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

**Українська (Ukrainian): УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

**ភាសាខ្មែរ (Khmer): ប្រយ័ត្ន៖** បើសិនអ្នកនិយាយខ្មែរ, សេវាជំនួយផ្នែក យេមិនគិតល គឺចូលសំបុំបំណែងអក្សរ ចូរទូរស័ព្ទ លេខ 1-888-901-4636 (TTY: 1-800-833-6388 / 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。1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、お電話にてご連絡ください。

**አማርኛ (Amharic) ፡ ማስታወሻ፡** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው፡ 1-800-833-6388 / 711)።

**Oromiffa (Oromo): XIYYEEFFANNA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

**ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 رقم هاتف الصم والبكم: (711 / 1-800-833-6388).

**Deutsch (German): ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

**ພາສາລາວ (Lao): ໂປດຊາບ:** ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍ່ວິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

**Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE:** Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

**Français (French): ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

**Română (Romanian): ATENȚIE:** Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

**Adamawa (Fulfulde): MAANDO:** To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

**فارسی (Farsi): توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.

## FOR MORE INFORMATION

Please contact HIHIT at  
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