



School Employees Benefits Board (SEBB) Program

2024 Kaiser Foundation Health Plan of Washington

Core and SoundChoice Plans for King, Kitsap, Pierce, Snohomish, Spokane, and Thurston counties

- **No copays for preventive care**, with no deductible.
- **No deductible for prescription drugs.** And mail-order pharmacy offers convenience and savings.
- **Convenient virtual care options.** Virtual care, including 24/7 Care Chat, 24/7 advice line, phone and video appointments, and more.
- **Manage your health anytime, anywhere.** With the Kaiser Permanente Washington app, it's easy for you to connect to care, resources, and wellness programs to help you live your healthiest life.

This is an overview of benefits. See your Evidence of Coverage for full benefit details.

Benefits (In-Network)	SoundChoice	Core 2	Core 1
Medical deductible (single/family)	\$125/\$375	\$750/\$2,250	\$1,250/\$3,750
Medical maximum out-of-pocket limit (single/family)	\$2,000/\$4,000	\$3,000/\$6,000	\$4,000/\$8,000
Telehealth			
Telemedicine (real time interactive audio and video communications with provider)	\$10*	\$10*	\$10*
Telephone Services and Online Visits	\$0*	\$0*	\$0*
Outpatient care			
Primary care	\$20 then 15%	\$25 then 20%	\$30 then 20%
Specialist	\$30 then 15%	\$35 then 20%	\$40 then 20%
Preventive care	\$0*	\$0*	\$0*
Behavioral health	\$20 then 15%	\$25 then 20%	\$30 then 20%
Diagnostic tests, X-ray/lab	15%	20%	20%
Hospital services	15%	20%	20%
Inpatient care			
Hospital services	15%	20%	20%
Obesity-related surgery (bariatric)	Member pays cost shares based on services provided; when medical criteria are met		
Emergency, urgent care, and transportation			
Emergency room	\$150 then 15%	\$150 then 20%	\$150 then 20%
Urgent care*	\$30 then 15%	\$25 then 20%	\$30 then 20%
Ambulance (air/ground, per trip)	20%*	20%*	20%*

2024 SEBB Core and SoundChoice Plans

Benefits (In-Network)	SoundChoice	Core 2	Core 1	
Rehabilitation, therapy, and alternative medicine				
Rehabilitation (occupational, physical, and speech therapy; pulmonary and cardiac rehabilitation) and neurodevelopmental therapy (NDT)	Combined therapy, 60 total visits per calendar year (no visit limit for NDT)			
	\$30 then 15%	\$35 then 20%	\$40 then 20%	
Massage therapy	24 visits per calendar year			
	\$30 then 15%	\$35 then 20%	\$40 then 20%	
Acupuncture	24 visits per calendar year			
	\$20 then 15%	\$25 then 20%	\$30 then 20%	
Chiropractic manipulations*	24 visits per calendar year			
	\$20 then 15%	\$25 then 20%	\$30 then 20%	
Naturopathy	Unlimited visits			
	\$20 then 15%	\$25 then 20%	\$30 then 20%	
Durable medical equipment, devices, and aids				
Durable medical equipment	Member pays any amount over \$300 for orthotic devices (per calendar year)			
	15%	20%	20%	
Hearing aids	\$0 up to \$3,000 per ear (every 36 months)*			
Prescription drugs				
Rx deductible	None			
Rx out-of-pocket limit	Combined with medical maximum out-of-pocket limit			
Preferred generic	Retail 30-day supply	\$10*	\$10*	\$5*
	Mail order 90-day supply	\$20*	\$20*	\$10*
Preferred brand	Retail 30-day supply	\$25*	\$25*	\$25*
	Mail order 90-day supply	\$50*	\$50*	\$50*
Nonpreferred generic and brand	Retail 30-day supply	\$50*	\$50*	\$50*
	Mail order 90-day supply	\$100*	\$100*	\$100*
Specialty	Retail 30-day supply	50% up to \$150*	50% up to \$150*	50% up to \$150*

Monthly employee premiums	SoundChoice	Core 2	Core 1
Employee	\$115	\$98	\$48
Employee and spouse**	\$230	\$196	\$96
Employee and children	\$201	\$172	\$84
Employee, spouse**, and children	\$345	\$294	\$144

* Specialty care visit copay will apply if service is rendered by a specialist.

- ♦ Not subject to annual deductible
- ♦♦ Or state-registered domestic partner

Virtual care is offered when appropriate and available.

If you have questions, please call Kaiser Permanente WA Member Services at **1-888-901-4636** (TTY 711).

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR EVIDENCE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your Evidence of Coverage.