

 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 1-800-278-3296 (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 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$250 Individual / \$500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and services indicated in chart starting on page 2.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other deductibles for specific services?	Yes. \$100 Individual for brand and specialty <u>prescription drugs</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$2,500 Individual / \$5,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of <u>network providers</u> . For an ARP Chemical Dependency provider , call the Assistance Recovery Program (ARP) at 1-800-562-3277.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network providers</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes , but you may self-refer to certain <u>specialists</u> .	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 / visit, <u>deductible</u> does not apply.	Not Covered	None
	<u>Specialist</u> visit	\$20 / visit, <u>deductible</u> does not apply.	Not Covered	None
	<u>Preventive care/ screening/ immunization</u>	No Charge, <u>deductible</u> does not apply.	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	20% <u>coinsurance</u> up to \$50 / - procedure	Not Covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/formulary.	Generic drugs	\$10 / prescription, <u>deductible</u> does not apply.	Not Covered	Up to a 100-day supply retail and mail order. Subject to <u>formulary</u> guidelines. No Charge for Contraceptives, <u>deductible</u> does not apply.
	Preferred brand drugs	\$30 / prescription, after drug <u>deductible</u> .	Not Covered	Up to a 100-day supply retail and mail order. Subject to <u>formulary</u> guidelines. No Charge for Contraceptives, <u>deductible</u> does not apply.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	<u>Specialty drugs</u>	20% <u>coinsurance</u> up to \$150 / prescription, after drug <u>deductible</u> .	Not Covered	Up to a 30-day supply retail. Subject to <u>formulary</u> guidelines.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	\$150 / trip	\$150 / trip	None
	<u>Urgent care</u>	\$20 / visit, <u>deductible</u> does not apply.	\$20 / visit, <u>deductible</u> does not apply.	<u>Non-Plan providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fee	20% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Kaiser: Mental/Behavioral Health: \$20/ visit, <u>deductible</u> does not apply. 20% <u>coinsurance</u> for other outpatient services; Substance Abuse: \$20/visit, <u>deductible</u> does not apply. 20% <u>coinsurance</u> up to \$5 / day for other outpatient services, <u>deductible</u> does not apply. ARP: No charge, <u>deductible</u> does not apply.	Kaiser and ARP: Not Covered	Kaiser: Mental / Behavioral Health: \$10 / group visit, <u>deductible</u> does not apply; Substance Abuse: \$5 / group visit, <u>deductible</u> does not apply. ARP: These supplemental chemical dependency benefits are for the employee and spouse only.
	Inpatient services	Kaiser: 20% <u>coinsurance</u> / individual visit ARP: No charge, <u>deductible</u> does not apply.	Kaiser and ARP: Not Covered	Kaiser: None ARP: These supplemental chemical dependency benefits are for the employee and spouse only. Elective hospitalization at an ARP facility requires <u>preauthorization</u> to avoid a \$300 penalty. For availability of benefits without prior authorization, please refer to your benefits available through Kaiser.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you are pregnant	Office visits	No Charge, <u>deductible</u> does not apply.	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge, <u>deductible</u> does not apply.	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	<u>Rehabilitation services</u>	Inpatient: 20% <u>coinsurance</u> ; Outpatient: \$20 / visit	Not Covered	None
	<u>Habilitation services</u>	\$20 / visit	Not Covered	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	Up to 100 days maximum / benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	Requires prior authorization.
	<u>Hospice service</u>	No Charge, <u>deductible</u> does not apply.	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge, <u>deductible</u> does not apply.	Not Covered	You may have additional vision benefits through a separate vision plan administered by VSP.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	You may have additional dental benefits through a separate dental plan administered by Delta Dental.

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.)

<ul style="list-style-type: none">• Chemical dependency services at an ARP provider for dependent children• Children's glasses (you may have additional vision benefits (adult and children) available through a separate benefit administered by VSP)• Cosmetic surgery	<ul style="list-style-type: none">• Dental Care (Adult & Child) (available only through a separate benefit administered by Delta Dental up to \$2,500/calendar year)• Long-term care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Private-duty nursing• Routine foot care• Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none">• Acupuncture (plan provider referred)• Bariatric surgery	<ul style="list-style-type: none">• Chiropractic care (20 visit limit / year)• Hearing aids (\$1,350/ear every 4 years, benefit available through the Fund)• Infertility treatment	<ul style="list-style-type: none">• Routine eye care (Adult) (you may have additional vision benefits (adult and children) available through a separate benefit administered by VSP)
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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	1-800-278-3296 (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.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.healthhelp.ca.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 1-800-788-0616 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585 (TTY: 711)

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-278-3296 (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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$250	■ The plan's overall deductible	\$250	■ The plan's overall deductible	\$250
■ Specialist copayment	\$20	■ Specialist copayment	\$20	■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other (blood work) copayment	\$10	■ Other (blood work) copayment	\$10	■ Other (x-ray) copayment	\$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*)

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*)
 Durable medical equipment (*crutches*)
 Diagnostic test (*x-ray*)
 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:			In this example, Joe would pay:			In this example, Mia would pay:		
Cost Sharing			Cost Sharing			Cost Sharing		
Deductibles*		\$300	Deductibles		\$200	Deductibles		\$300
Copays		\$50	Copays		\$800	Copays		\$300
Coinsurance		\$1,700	Coinsurance		\$100	Coinsurance		\$200
What isn't covered			What isn't covered			What isn't covered		
Limits or exclusions		\$50	Limits or exclusions		\$0	Limits or exclusions		\$0
The total Peg would pay is		\$2,100	The total Joe would pay is		\$1,100	The total Mia would pay is		\$800

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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