



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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your deductible?</b>	Not Applicable.	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.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$1,500 Individual / \$3,000 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.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) for a list of <u>network providers</u> .	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.
<b>Do you need a referral to see a specialist?</b>	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
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15 / visit	Not Covered	None
	<u>Specialist</u> visit	\$15 / visit	Not Covered	None
	<u>Preventive care/ screening/ immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs	Retail: \$10 / prescription; Mail order: \$20 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <u>formulary guidelines</u> . No Charge for Contraceptives.
	Preferred brand drugs	Retail: \$20 / prescription; Mail order: \$40 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <u>formulary guidelines</u> . No Charge for Contraceptives.
	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	Not Covered	Up to a 30-day supply retail. Subject to <u>formulary guidelines</u> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$15 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None

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 need immediate medical attention	<u>Emergency room care</u>	\$50 / visit	\$50 / visit	None
	<u>Emergency medical transportation</u>	\$50 / trip	\$50 / trip	None
	<u>Urgent care</u>	\$15 / visit	\$15 / visit	<u>Non-Plan providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 / admission	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Kaiser:</b> Mental / Behavioral Health: \$15 / individual visit. No Charge for other outpatient services; Substance Abuse: \$15 / individual visit. \$5 / day for other outpatient services <b>ARP:</b> No charge	<b>Kaiser and ARP:</b> Not Covered	<b>Kaiser:</b> Mental / Behavioral Health: \$7 / group visit; Substance Abuse: \$5 / group visit. <b>ARP:</b> Additional substance abuse benefits available through Assistance Recovery Program (ARP).
	Inpatient services	<b>Kaiser:</b> \$100 / admission <b>ARP:</b> No charge	<b>Kaiser and ARP:</b> Not Covered	<b>Additional substance abuse benefits are available through Assistance Recovery Program (ARP).</b> <u>Preauthorization</u> by ARP is required if you are not Medicare eligible.
If you are pregnant	Office visits	No Charge	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	No Charge	Not Covered	None
	Childbirth/delivery facility services	\$100 / admission	Not Covered	None

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
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	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: \$100 / admission; Outpatient: \$15 / visit	Not Covered	None
	<u>Habilitation services</u>	\$15 / visit	Not Covered	None
	<u>Skilled nursing care</u>	No Charge	Not Covered	Up to 100 days maximum / benefit period.
	<u>Durable medical equipment</u>	No Charge	Not Covered	Requires prior authorization.
	<u>Hospice service</u>	No Charge	Not Covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	If you elect additional vision coverage, it will be available under a separate vision <u>plan</u> .
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If you elect dental coverage, it will be available under the low option or high option separate dental <u>plan</u> .

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>Children's glasses</li> <li>Cosmetic surgery</li> <li>Dental Care (Adult &amp; Child) covered under a separate dental <u>plan</u>.</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>		
<ul style="list-style-type: none"> <li>Acupuncture (plan provider referred)</li> <li>Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care (20 visit limit / year)</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult) additional coverage available under a separate vision <u>plan</u>.</li> </ul>

**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](http://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 <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>
California Department of Insurance	1-800-927-HELP (4357) or <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a>
California Department of Managed Healthcare	1-888-466-2219 or <a href="http://www.healthhelp.ca.gov/">www.healthhelp.ca.gov/</a>

### 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, kwijigo 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)	
■ <u>The plan's overall deductible</u>	\$0	■ <u>The plan's overall deductible</u>	\$0	■ <u>The plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$15	■ <u>Specialist copayment</u>	\$15	■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) copayment</u>	\$100	■ <u>Hospital (facility) copayment</u>	\$100	■ <u>Hospital (facility) copayment</u>	\$100
■ <u>Other (blood work) copayment</u>	\$0	■ <u>Other (blood work) copayment</u>	\$0	■ <u>Other (x-ray) copayment</u>	\$0
<p><b>This EXAMPLE event includes services like:</b>  <u>Specialist office visits (prenatal care)</u>                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <u>Diagnostic tests (ultrasounds and blood work)</u>  <u>Specialist visit (anesthesia)</u></p>		<p><b>This EXAMPLE event includes services like:</b>  <u>Primary care physician office visits (including disease education)</u>  <u>Diagnostic tests (blood work)</u>  <u>Prescription drugs</u>  <u>Durable medical equipment (glucose meter)</u></p>		<p><b>This EXAMPLE event includes services like:</b>  <u>Emergency room care (including medical supplies)</u>  <u>Diagnostic test (x-ray)</u>  <u>Durable medical equipment (crutches)</u>  <u>Rehabilitation services (physical therapy)</u></p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100	<u>Copayments</u>	\$600	<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$50	Limits or exclusions	\$0	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$150</b>	<b>The total Joe would pay is</b>	<b>\$600</b>	<b>The total Mia would pay is</b>	<b>\$200</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.