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 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.
Are there other deductibles for specific services?	**Yes. $100** Individual for brand and specialty prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$2,500** Individual / **$5,000** Family	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?	Premiums, 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 1-800-278-3296 (TTY: 711) for a list of network providers. For an **ARP Chemical Dependency provider**, call the Assistance Recovery Program (ARP) at 1-800-562-3277.	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 providers 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?	**Yes**, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit, deductible does not apply.	Not Covered	None
	Specialist visit	$20 / visit, deductible does not apply.	Not Covered	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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	20% coinsurance up to $50 / - procedure	Not Covered	None
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.kp.org/ formulary.**	Generic drugs	$10 / prescription , deductible does not apply.	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives, deductible does not apply.
	Preferred brand drugs	$30 / prescription , after drug deductible.	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives, deductible does not apply.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	20% coinsurance up to $150 / prescription, after drug deductible.	Not Covered	Up to a 30-day supply retail. Subject to formulary 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 will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	$150 / trip	$150 / trip	None
	Urgent care	$20 / visit, deductible does not apply.	$20 / visit, deductible does not apply.	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	None
	Physician/surgeon fee	20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Kaiser:** Mental/Behavioral Health: $20/ visit, deductible does not apply. 20% coinsurance for other outpatient services; Substance Abuse: $20/visit, deductible does not apply. 20% coinsurance up to $5 / day for other outpatient services, deductible does not apply. **ARP**: No charge, deductible	**Kaiser and ARP:** Not Covered	**Kaiser:** Mental / Behavioral Health: $10 / group visit, deductible does not apply; Substance Abuse: $5 / group visit, deductible does not apply. **ARP**: These supplemental chemical dependency benefits are for the employee and spouse only.
	Inpatient services	**Kaiser:** 20% coinsurance / individual visit **ARP**: No charge, deductible 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 preauthorization 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, deductible does not apply.	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No Charge, deductible does not apply.	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	Rehabilitation services	Inpatient: 20% coinsurance; Outpatient: $20 / visit	Not Covered	None
	Habilitation services	$20 / visit	Not Covered	None
	Skilled nursing care	20% coinsurance	Not Covered	Up to 100 days maximum / benefit period.
	Durable medical equipment	20% coinsurance, deductible does not apply.	Not Covered	Requires prior authorization.
	Hospice service	No Charge, deductible does not apply.	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge, deductible 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.)		
● 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	● 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.	● Private-duty nursing ● Routine foot care ● Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
● Acupuncture (plan provider referred) ● Bariatric surgery	● Chiropractic care (20 visit limit / year) ● Hearing aids ($1,350/ear every 4 years, benefit available through the Fund) ● Infertility treatment	● Routine eye care (Adult) (you may have additional vision benefits (adult and children) available through a separate benefit administered by VSP)

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, kwiijigo 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)	
The plan's overall deductible	**$250**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other (blood work) 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*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$300
Copays	$50
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$2,100**

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	**20%**
Other (blood work) copayment	**$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:	
Cost Sharing	
Deductibles	$200
Copays	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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	**20%**
Other (x-ray) copayment	**$10**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copays	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
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.

This page is intentionally left blank.