



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, 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:
What is the overall <u>deductible</u> ?	<b>\$500</b> per individual / <b>\$1,000</b> per 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 <u>deductible</u> ?	Yes. <u>Preventive care</u> , <u>prescription drugs</u> , and services indicated in the 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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<b>\$3,000</b> individual / <b>\$6,000</b> 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, and services indicated in the 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 <u>network provider</u> ?	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 provider <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 provider</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 <u>referral</u> to see a <u>specialist</u> ?	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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's 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	Services related to infertility covered at 50% <u>coinsurance</u> / visit.
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge, <u>deductible</u> does not apply.	Not Covered	You may have to pay for services that aren't <u>preventative</u> . Ask your <u>provider</u> if the services you need are <u>preventative</u> . 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, <u>deductible</u> does not apply.	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$50 / procedure, <u>deductible</u> does not apply.	Not Covered	None
If you need drugs to treat your illness or condition  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	\$10 / prescription for 1 to 30 days, <u>deductible</u> does not apply; Mail order: Usually two times the <u>plan</u> pharmacy <u>cost sharing</u> for up to a 100-day supply.	Not Covered	In accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share.
	Brand drugs	\$30 / prescription for 1 to 30 days, <u>deductible</u> does not apply; Mail order: Usually two times the <u>plan</u> pharmacy <u>cost sharing</u> for up to a 100-day supply.	Not Covered	In accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share.
	<u>Specialty drugs</u>	\$30 / prescription for 1 to 30 days, <u>deductible</u> does not apply; Mail order: Usually two times the <u>plan</u> pharmacy <u>cost sharing</u> for up to a 100-day supply.	Not Covered	In accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> / procedure	Not Covered	None
	Physician/surgeon fees	10% <u>coinsurance</u> / procedure	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> / visit	10% <u>coinsurance</u> / visit	None
	<u>Emergency medical transportation</u>	\$150 / trip, <u>deductible</u> does not apply.	\$150 / trip, <u>deductible</u> does not apply.	None
	<u>Urgent care</u>	\$20 / visit, <u>deductible</u> does not apply.	\$20 / visit, <u>deductible</u> does not apply.	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> / admission	Not Covered	None
	Physician/surgeon fee	10% <u>coinsurance</u> / admission	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	Mental / Behavioral Health: \$20 / individual visit, <u>deductible</u> does not apply. 10% <u>coinsurance</u> / day for other outpatient services. Substance abuse: \$20 / individual visit, <u>deductible</u> does not apply. 10% <u>coinsurance</u> / day up to \$5 maximum for other outpatient services, <u>deductible</u> does not apply.	Not Covered	Mental / Behavioral Health: \$10 / group visit Substance Abuse: \$5 / group visit
	Inpatient services	10% <u>coinsurance</u> / admission	Not Covered	None

<b>If you are pregnant</b>	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	10% <u>coinsurance</u> / admission	Not Covered	None
	Childbirth/delivery facility services	10% <u>coinsurance</u> / admission	Not Covered	None
<b>If you need help recovering or have other special health needs</b>	<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: 10% <u>coinsurance</u> / admission Outpatient: \$20 / visit, <u>deductible</u> does not apply.	Not Covered	None
	<u>Habilitation services</u>	\$20 / visit, <u>deductible</u> does not apply.	Not Covered	None
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> / admission, <u>deductible</u> does not apply.	Not Covered	Up to 100 days maximum / benefit period.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> / item, <u>deductible</u> does not apply.	Not Covered	Must be in accordance with <u>formulary</u> guidelines. Requires <u>preauthorization</u> .
	<u>Hospice service</u>	No Charge, <u>deductible</u> does not apply.	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge, <u>deductible</u> does not apply.	Not Covered	None
	Children's glasses	Amount in excess of a \$150 allowance, <u>deductible</u> does not apply.	Not Covered	Allowance limited to once every 24 months. You may have other optical coverage not described here. Refer to "Other Covered Services" for additional information.
	Children's dental check-up	Not Covered	Not Covered	None

## Excluded Services & Other Covered Services:

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> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care unless <u>medical necessary</u></li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (30 visit limit / year combined with chiropractic)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (30 visit limit / year combined with acupuncture)</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult) and eyewear allowance (Adult)</li> <li>• Hearing Aids</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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 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 agency in the chart below. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care and Department of Insurance at 980 9th St, Suite #500 Sacramento, CA 95814, 1-888-466-2219 or <http://www.HealthHelp.ca.gov>.

### 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### Does this plan meet 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)

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*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 \$500
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other (blood work) copayment \$0

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,560</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$500
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other (blood work) copayment \$0

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,160</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$500
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other (x-ray) copayment \$0

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>

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