

 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 <https://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> ?	\$2,000 Self only enrollment, \$2,600 for any one member within a Family enrollment, \$4,000 for an entire 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> 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 <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> ?	\$3,000 Self only enrollment, \$3,000 for any one member within a Family enrollment, \$6,000 for an entire 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 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 www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of <u>plan 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 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 <u>referral</u> to see a <u>specialist</u> ?	Yes, but you may self-refer to certain specialists.	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	\$30 / visit	Not Covered	None
	<u>Specialist</u> visit	\$30 / visit	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 <u>preventive</u> . 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)	\$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	Plan pharmacy: \$10 / prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	Plan pharmacy: \$30 / prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	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> / prescription up to \$150 maximum for 1 to 30 days	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.

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)	\$150 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	\$100 / visit	\$100 / visit	None
	Emergency medical transportation	\$100 / trip	\$100 / trip	None
	Urgent care	\$30 / visit	\$30 / visit	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 / admission	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral Health: \$30 / individual visit. No Charge for other outpatient services; Substance Abuse: \$30 / individual visit. \$5 / day for other outpatient services	Not Covered	Mental / Behavioral Health: \$15 / group visit; Substance Abuse: \$5 / group visit.
	Inpatient services	\$250 / 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
If you are pregnant	Office visits	Prenatal care: No Charge, <u>deductible</u> does not apply; Postnatal care: \$10 / visit	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	\$250 / admission	Not Covered	None
	Childbirth/delivery facility services	\$250 / admission	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	Rehabilitation services	Inpatient: \$250 / admission; Outpatient: \$30 / visit	Not Covered	None
	Habilitation services	\$30 / visit	Not Covered	None
	Skilled nursing care	\$250 / admission	Not Covered	Up to 100 days maximum / benefit period.
	Durable medical equipment	20% coinsurance / item	Not Covered	Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.
If your child needs dental or eye care	Children's eye exam	\$30 / visit, deductible does not apply.	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

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"> • Chiropractic care • Cosmetic surgery • Dental care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care unless medically necessary • Weight loss programs
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) 	<ul style="list-style-type: none"> • Bariatric surgery 	<ul style="list-style-type: none"> • Routine eye care (Adult)

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 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 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

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 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, kwijjigo 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	\$4,000	■ The plan's overall deductible	\$2,600	■ The plan's overall deductible	\$2,600
■ Specialist copayment	\$30	■ Specialist copayment	\$30	■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$250	■ Hospital (facility) copayment	\$250	■ Hospital (facility) copayment	\$250
■ 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	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$2,600	Deductibles	\$2,600	Deductibles	\$1,000
Copayments	\$400	Copayments	\$300	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$80	Coinsurance	\$10
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$100	Limits or exclusions	\$0
The total Peg would pay is	\$3,060	The total Joe would pay is	\$3,080	The total Mia would pay is	\$1,010

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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