




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 ? | \$2,500 Individual / \$5,000 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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$6,350 Individual / \$12,700 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 Plan Providers . | 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 provider 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 | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | Plan Provider (You will pay the least) | Non-Plan 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 | \$30 / visit, deductible does not apply. | Not covered | None |
| | Specialist visit | \$60 / 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 needed are preventive . Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | X-ray: 20% coinsurance Lab tests: 20% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 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 (Tier 1) | \$10 (retail); \$20 (mail order) / prescription , deductible does not apply. | Not covered | Up to a 30-day supply (retail); up to a 100-day supply (mail order). No charge, deductible does not apply for contraceptives. Subject to formulary guidelines. |
| | Preferred brand drugs (Tier 2) | 20% coinsurance up to \$100 (retail); 20% coinsurance up to \$100 (mail order) / prescription , deductible does not apply. | Not covered | Up to a 30-day supply (retail); up to a 100-day supply (mail order). Subject to formulary guidelines. |
| | Non-preferred brand drugs (Tier 2) | 20% coinsurance up to \$100 (retail); 20% coinsurance up to \$100 (mail order) / prescription , deductible does not apply. | Not covered | Up to a 30-day supply (retail); up to a 100-day supply (mail order). The cost share for non-preferred brand drugs is the same as preferred brand drugs, when approved through the formulary exception process. |
| | Specialty drugs (Tier 4) | 40% coinsurance up to \$150 (retail) / prescription , deductible does not apply. | Not covered | Up to a 30-day supply (retail). Subject to formulary guidelines. |
| 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 |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Plan Provider (You will pay the least) | Non-Plan Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| | Urgent care | \$30 / visit, deductible does not apply. | Not covered | Non-Plan Providers covered when temporarily outside the service area: \$30 / visit, deductible does not apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Mental / Behavioral health: \$30 / individual visit, deductible does not apply. 20% coinsurance for other outpatient services, deductible does not apply. Substance abuse: \$30 / individual visit, deductible does not apply. 20% coinsurance up to \$15 / day for other outpatient services, deductible does not apply. | Not covered | \$15 / group visit, deductible does not apply. |
| | Inpatient services | 20% coinsurance | Not covered | None |
| 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 |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | Plan Provider (You will pay the least) | Non-Plan Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance , deductible does not apply. | Not covered | 3 visit limit / day, 100 visit limit / year. |
| | Rehabilitation services | Outpatient: \$30 / visit Inpatient: 20% coinsurance | Not covered | None |
| | Habilitation services | \$30 / visit | Not covered | None |
| | Skilled nursing care | 20% coinsurance | Not covered | 100-day limit / benefit period. |
| | Durable medical equipment | 20% coinsurance , deductible does not apply. | Not covered | Prior authorization required. |
| | Hospice services | 20% coinsurance , deductible does not apply. | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | No charge for refractive exam, deductible does not apply. | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

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"> Children's glasses Cosmetic surgery Dental care (Adult and child) | <ul style="list-style-type: none"> Hearing aids 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 |
| 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 (30 visit limit / year) Infertility treatment | <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 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.dmhc.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).

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-757-7585 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 (TTY: 711).

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-800-278-3296 (TTY: 711) uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-278-3296 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 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 | \$2,500 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other (blood work) coinsurance | 20% |

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 | \$2,500 |
| Copayments | \$10 |
| Coinsurance | \$1,500 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$50 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$4,060 |
|-----------------------------------|----------------|

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,500 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other (blood work) coinsurance | 20% |

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 | \$90 |
| Copayments | \$700 |
| Coinsurance | \$100 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|--------------|
| The total Joe would pay is | \$890 |
|-----------------------------------|--------------|

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,500 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other (x-ray) coinsurance | 20% |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

Cost Sharing

| | |
|-----------------------------|---------|
| Deductibles | \$2,400 |
| Copayments | \$100 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$2,500 |
|-----------------------------------|----------------|

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