



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 <https://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 <a href="#">deductible</a>?</b>	\$1,000 Individual / \$2,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$4,000 Individual / \$8,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</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 <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why this Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes, but you may self-refer to certain <a href="#">specialists</a> .	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 / visit, <a href="#">deductible</a> does not apply.	Not Covered	None
	<a href="#">Specialist</a> visit	\$20 / visit, <a href="#">deductible</a> does not apply.	Not Covered	None
	<a href="#">Preventive care/ screening/ immunization</a>	No Charge, <a href="#">deductible</a> does not apply.	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$10 / encounter, <a href="#">deductible</a> does not apply.	Not Covered	None
	Imaging (CT/PET scans, MRI's)	20% <a href="#">coinsurance</a> up to \$150 / procedure, <a href="#">deductible</a> does not apply.	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 drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs (Tier 1)	Retail: \$10 / <a href="#">prescription</a> ; Mail order: \$20 / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines. No Charge for Contraceptives, <a href="#">deductible</a> does not apply.
	Preferred brand drugs (Tier 2)	Retail: \$30 / <a href="#">prescription</a> ; Mail order: \$60 / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines.
	Non-preferred brand drugs (Tier 2)	Retail: \$30 / <a href="#">prescription</a> ; Mail order: \$60 / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.	Not Covered	The <a href="#">cost sharing</a> for non-preferred brand drugs under this <a href="#">plan</a> aligns with the <a href="#">cost sharing</a> for preferred brand drugs (Tier 2), when approved through the <a href="#">formulary</a> exception process.
	<a href="#">Specialty drugs</a> (Tier 4)	20% <a href="#">coinsurance</a> up to \$250 / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.	Not Covered	Up to a 30-day supply retail. Subject to <a href="#">formulary</a> guidelines.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not Covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	\$150 / trip, <a href="#">deductible</a> does not apply.	\$150 / trip, <a href="#">deductible</a> does not apply.	None
	<a href="#">Urgent care</a>	\$20 / visit, <a href="#">deductible</a> does not apply.	Not Covered	<a href="#">Non-Plan providers</a> covered when temporarily outside the service area: \$20 / visit, <a href="#">deductible</a> does not apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not Covered	None
	Physician/surgeon fee	20% <a href="#">coinsurance</a>	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 mental health, behavioral health, or substance abuse services</b>	Outpatient services	Mental / Behavioral Health: \$20 / individual visit, <a href="#">deductible</a> does not apply. 20% <a href="#">coinsurance</a> for other outpatient services, <a href="#">deductible</a> does not apply; Substance Abuse: \$20 / individual visit, <a href="#">deductible</a> does not apply. 20% <a href="#">coinsurance</a> up to \$5 / day for other outpatient services, <a href="#">deductible</a> does not apply.	Not Covered	Mental / Behavioral Health: \$10 / group visit, <a href="#">deductible</a> does not apply; Substance Abuse: \$5 / group visit, <a href="#">deductible</a> does not apply.
	Inpatient services	20% <a href="#">coinsurance</a>	Not Covered	None
<b>If you are pregnant</b>	Office visits	No Charge, <a href="#">deductible</a> does not apply.	Not covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not Covered	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	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 help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge, <a href="#">deductible</a> does not apply.	Not Covered	3 visit limit / day, 4-hour limit / visit, 100 visit limit / year.
	<a href="#">Rehabilitation services</a>	Inpatient: 20% <a href="#">coinsurance</a> ; Outpatient: \$20 / visit, <a href="#">deductible</a> does not apply.	Not Covered	None
	<a href="#">Habilitation services</a>	\$20 / visit, <a href="#">deductible</a> does not apply.	Not Covered	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	Not Covered	100 day limit / benefit period.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	Not Covered	Requires prior authorization.
	<a href="#">Hospice service</a>	No Charge, <a href="#">deductible</a> does not apply.	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam, <a href="#">deductible</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Children's glasses</li> <li>• Cosmetic surgery</li> <li>• Dental Care (Adult &amp; Child)</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>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> 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)</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.dmhc.ca.gov">www.dmhc.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)

TRADITIONAL 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)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-278-3296 (TTY: 711) uff

NAVAJO (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 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, à’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](#) \$1,000
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$2,620</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$900</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other (x-ray) [copayment](#) \$10

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>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

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