



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>\$0</b> per individual / <b>\$0</b> per family  | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.   |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> , <u>prescription drugs</u> , and primary care services are covered before you meet your <u>deductible</u> . | 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>\$1,500</b> individual / <b>\$3,000</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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <u>provider's</u> office or clinic   | Primary care visit to treat an injury or illness        | \$0 / visit                                  | Not Covered  | None  |
|   | <u>Specialist</u> visit                                 | \$0 / visit                                  | Not Covered  | Services related to infertility covered at \$0 / visit.   |
|   | <u>Preventive care</u> / <u>screening</u> /immunization | No Charge                                    | 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)              | No Charge                                    | Not Covered  | None  |
|   | Imaging (CT/PET scans, MRIs)                            | No Charge                                    | Not Covered  | None  |
| If you need drugs to treat your illness or condition<br><br>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   | \$5 / prescription for 1 to 100 days         | Not Covered  | In accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share.   |
|   | Brand drugs   | \$5 / prescription for 1 to 100 days         | Not Covered  | In accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share.   |
|   | <u>Specialty drugs</u>                                  | \$5 / prescription for 1 to 30 days          | Not Covered  | In accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share.   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)          | \$0 / procedure                              | Not Covered  | None  |
|   | Physician/surgeon fees                                  | No Charge                                    | Not Covered  | None  |

| Common Medical Event   | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| If you need immediate medical attention                                | <u>Emergency room care</u>                | \$100 / visit  | \$100 / visit                                      | None   |
|  | <u>Emergency medical transportation</u>   | \$50 / trip  | \$50 / trip  | None   |
|  | <u>Urgent care</u>                        | \$0 / visit  | \$0 / visit  | Non-Plan providers covered when outside the service area.  |
| If you have a hospital stay  | Facility fee (e.g., hospital room)        | No Charge  | Not Covered  | None   |
|  | Physician/surgeon fee                     | No Charge  | Not Covered  | None   |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services                       | Mental / Behavioral Health: \$0 / individual visit. No Charge for other outpatient services;<br>Substance Abuse: \$0 / individual visit.<br>\$0 / day for other outpatient services. | Not Covered  | Mental / Behavioral Health: \$0 / group visit<br>Substance Abuse: \$0 / group visit  |
|  | Inpatient services                        | No Charge  | Not Covered  | None   |
| If you are pregnant  | Office Visits                             | No Charge  | 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 | No Charge  | Not Covered  | None   |
|  | Childbirth/delivery facility services     | No Charge  | Not Covered  | None   |

| Common Medical Event  | Services You May Need            | What You Will Pay                               |  | Limitations, Exceptions, & Other Important Information  |
|---|----------------------------------|---|--|---|
|   |                                  | Network Provider<br>(You will pay the least)    | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | No Charge                                       | 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: No Charge<br>Outpatient: \$0 / visit | Not Covered  | None  |
|   | <u>Habilitation services</u>     | \$0 / visit                                     | Not Covered  | None  |
|   | <u>Skilled nursing care</u>      | No Charge                                       | Not Covered  | Up to 100 days maximum / benefit period.  |
|   | <u>Durable medical equipment</u> | No Charge                                       | Not Covered  | Must be in accordance with <u>formulary</u> guidelines. Requires <u>preauthorization</u> .    |
|   | <u>Hospice service</u>           | No Charge                                       | 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                                       | 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 <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)</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)

---

*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 \$0
- Specialist copayment \$0
- Hospital (facility) copayment \$0
- Other (blood work) copayment \$0

- The plan's overall deductible \$0
- Specialist copayment \$0
- Hospital (facility) copayment \$0
- Other (blood work) copayment \$0

- The plan's overall deductible \$0
- Specialist copayment \$0
- Hospital (facility) copayment \$0
- Other (x-ray) 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*)

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*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |             |
|-----------------------------------|-------------|
| Deductibles                       | \$0         |
| Copayments                        | \$10        |
| Coinsurance                       | \$0         |
| <i>What isn't covered</i>         |             |
| Limits or exclusions              | \$60        |
| <b>The total Peg would pay is</b> | <b>\$70</b> |

In this example, Joe would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$300        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Joe would pay is</b> | <b>\$360</b> |

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$200        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$200</b> |

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