




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](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not Applicable.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,500 Individual / \$3,000 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , and health care services this <a href="#">plan</a> doesn't cover, 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	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 <a href="#">plan's 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 <a href="#">provider's</a> 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.
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		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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 / visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$15 / visit	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	\$15 / visit	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)	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  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	\$15 / <a href="#">prescription</a>	Not Covered	Up to a 30-day supply retail or mail order. <b>Most outpatient <a href="#">prescription drugs</a> are not covered.</b>
	Preferred brand drugs	\$15 / <a href="#">prescription</a>	Not Covered	Up to a 30-day supply retail or mail order. <b>Most outpatient <a href="#">prescription drugs</a> are not covered.</b>
	Non-preferred brand drugs	\$15 / <a href="#">prescription</a>	Not Covered	Same as preferred brand drugs when approved through exception process.
	<a href="#">Specialty drugs</a>	\$15 / <a href="#">prescription</a>	Not Covered	Up to 30-day supply retail. Subject to <a href="#">formulary</a> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$15 / 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
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$35 / visit	\$35 / visit	None
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	None
	<a href="#">Urgent care</a>	\$15 / visit	\$15 / visit	Non- <a href="#">Plan providers</a> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No 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: \$15 / individual visit. No Charge for other outpatient services; Substance Abuse: \$15 / individual visit. \$5 / day for other outpatient services	Not Covered	Mental / Behavioral health: \$7 / group visit; Substance Abuse: \$5 / group visit
	Inpatient services	No Charge	No Covered	None
If you are pregnant	Office visits	\$15 / visit	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	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	None

If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	Up to 2 hour limit / visit, up to 3 visit limit / day, up to 100 visit limit / year
	<a href="#">Rehabilitation services</a>	Inpatient: No Charge; Outpatient: \$15 / visit	Not Covered	None
	<a href="#">Habilitation services</a>	\$15 / visit	Not Covered	None
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	100 day limit / benefit period.
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	Limited to base-covered items in accordance with <a href="#">formulary</a> guidelines. Requires prior authorization.
	<a href="#">Hospice services</a>	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$15 / visit	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:

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care unless medically necessary</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (plan provider referred)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (20 visit limit / year)</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 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. 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 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, 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)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other (blood work) <a href="#">copayment</a>	\$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	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$300</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other (blood work) <a href="#">copayment</a>	\$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	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,600</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other (x-ray) <a href="#">copayment</a>	\$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	\$0
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$100</b>