




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 1-877-568-0774 (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:
<p>What is the overall deductible?</p>	<p>Medical In-Network Provider: \$800 Individual \$1,600 Employee + Spouse or Child(ren) \$2,400 Family Medical Out-of-Network Provider: \$2,250 Individual \$4,500 Employee + Spouse or Child(ren) \$6,750 Family Prescription Drugs: Not Applicable</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care and network generic, preferred brand and non-preferred brand prescription drugs.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Medical In-Network Provider: \$3,000 Individual \$6,000 Employee + Spouse or Child(ren) \$9,000 Family Medical Out-of-Network Provider: \$7,500 Individual \$15,000 Employee + Spouse or Child(ren) \$22,500 Family Prescription Drugs: \$1,500 Individual / \$5,950 Family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance billing charges and health care this plan doesn't cover, and services indicated in chart starting on page 2.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-866-213-3062 (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
		Network Provider (You will pay the least)	Out-of-Network 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	20% coinsurance	40% coinsurance	None. Virtual Visits are covered at \$0 / visit; deductible waived
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No charge, deductible does not apply	40% coinsurance	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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	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) / Specialty Deductible does not apply	Retail: 20% coinsurance (\$5 min / \$10 max per prescription) Mail Order: 20% coinsurance (\$12.50 min / \$25 max per prescription)	Retail: 50% coinsurance ; Mail order is not covered	In-Network: \$1,500 Out-of-Pocket max / person up to, \$5,950 total for family (in- network and mail order). No charge for contraceptives, subject to formulary guidelines Retail: up to 30 day supply Mail Order: up to 100 day supply
	Preferred brand drugs (Tier 2) / Specialty Deductible does not apply	Retail: 30% coinsurance (\$30 min / \$45 max per	Retail: 50% coinsurance ; Mail order is not covered	In-Network: \$1,500 Out-of-Pocket max / person up to, \$5,950 total for family (in- network and mail order). No charge for contraceptives, subject to

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		prescription Mail Order: 30% coinsurance (\$75 min / \$112.50 max per prescription)		formulary guidelines Retail: up to 30 day supply Mail Order: up to 100 day supply
	Non-preferred brand drugs (Tier 3) / Specialty Deductible does not apply	Retail: 40% coinsurance (\$50 min / \$75 max per prescription) Mail Order: 40% coinsurance (\$125 min / \$187.50 max per prescription)	Retail: 50% coinsurance ; Mail order is not covered	In-Network: \$1,500 Out-of-Pocket max / person up to, \$5,950 total for family (in- network and mail order). No charge for contraceptives, subject to formulary guidelines Retail: up to 30 day supply Mail Order: up to 100 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	40% coinsurance	None
	Inpatient services	0% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	No charge	40% coinsurance	In-Network: 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.) Out-of-Network: Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	Subject to formulary guidelines
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Refractive care due to illness or injury to the eye are covered at plan coinsurance . See your Davis Vision benefit information for details.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	See your Delta Dental benefit information for details.

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 & Child) 	<ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing 	<ul style="list-style-type: none"> Routine eye care (Adult & Child) Routine foot care Weight loss programs, except for as required by the health care reform law

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 (up to a max of \$750 / calendar year) Bariatric surgery 	<ul style="list-style-type: none"> Chiropractic care (up to a max of \$750 / calendar year) Hearing aids (One aid / ear every 36 months for minors under 21) 	<ul style="list-style-type: none"> Infertility treatment

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	1-800-788-0710 (TTY: 711)
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

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 1-877-568-0774 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-568-0774 (TTY: 711)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-568-0774 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-568-0774 (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](#) \$800
- [Specialist Coinsurance](#) 20%
- Hospital (facility) [Coinsurance](#) 20%
- Other [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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$0
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$800
- [Specialist Coinsurance](#) 20%
- Hospital (facility) [Coinsurance](#) 20%
- Other [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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$0
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$800
- [Specialist Coinsurance](#) 20%
- Hospital (facility) [Coinsurance](#) 20%
- Other [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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$0
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200

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