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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	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?	*Medical out-of-pocket limit:* $1,500 Individual / $3,000 Family *Prescription drug out-of-pocket limit:* (applicable to prescription drugs from network pharmacies, *except certain specialty drugs*): $750 Individual / $1,500 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?	*Medical out-of-pocket limit:* premiums, prescription drug costs, health care services this plan doesn't cover, and services indicated in chart on page 2. *Prescription drug out-of-pocket limit (in-network):* premiums, amounts (other than copayment) paid for brand drug when generic is available, copayments for certain specialty drugs, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
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 network 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	$15 / visit	Not covered	None
	Specialist visit	$15 / visit	Not covered	None
	Preventive care/screening/ immunization	No charge	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)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.expressscripts.com or call 1-800-451-6245.	Generic drugs	$3 copay / prescription (retail or Mail order)	Not covered	You must use a pharmacy in Express Scripts' Prime Network (within the United States) to fill your prescription or no coverage. Each retail prescription limited to a maximum 30-day supply. For maintenance medications, up to a 90-day supply is available using mail order. For maintenance drugs, you must decide whether to use mail order or a retail pharmacy. Two retail fills are allowed before you must notify Express Scripts of your decision. Except in case of urgent medical need, specialty medications must be filled through the Accredo pharmacy. Some drugs require preauthorization. If you use a brand name drug when a generic is available, you will pay the difference in price between the brand name and the generic drug, plus the applicable copay. No charge for ACA-required preventive care drugs if purchased at a network pharmacy with a prescription. For information on drugs not covered by the plan, call 1-800-451-6245, visit www.express-scripts.com, or download the Express Scripts app.
	Brand name drugs	$6 copay / prescription (retail) $5 copay / prescription (mail order)	Not Covered	
	Specialty drugs	$3 copay for generic (retail or mail order) $ 6 copay / brand prescription (retail) $5 copay / brand prescription (mail order)	Not covered	Certain specialty drugs have substantially higher copays than shown. If you are on one of these specialty drugs and you participate in the SaveOn SP program through Express Scripts, you will not have to pay the higher copays. However, if your specialty drug is on the SaveOn SP Drug list and you do not participate in the SaveOn SP program, you will be responsible for the full copay. The specialty drugs on the SaveOn SP Drug list, and the copays for those drugs, are subject to change. You will receive notification from SaveOn SP if you are on a specialty drug that is part of the SaveOn SP program. Please see "Important Questions" on page 1 for more information regarding the prescription drug out-of-pocket limit.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$15 / procedure	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$150 / visit	$150 / visit	None
	Emergency medical transportation	$50 / trip	$50 / trip	None
	Urgent care	$15 / visit	$15 / visit	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not 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	Not covered	None
If you are pregnant	Office visits	No charge	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	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
		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	No charge	Not covered	Up to 2-hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	Rehabilitation services	Inpatient: No charge Outpatient: $15 / visit	Not covered	None
	Habilitation services	$15 / visit	Not covered	None
	Skilled nursing care	No charge	Not covered	Up to 100 days maximum / benefit period.
	Durable medical equipment	20% coinsurance	Not covered	Limited to base-covered items in accordance with formulary guidelines. Requires prior authorization
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Covered through Kaiser (not covered through Vision Service Plan).
	Children's glasses	Kaiser: Not covered VSP: No charge for frames under $120 allowance (80% of costs above $120). No charge for most standard lenses.	Kaiser: Not covered VSP: Frames: All costs above $70. Lenses: All costs above $30 (single vision lenses), $50 (bifocals and standard progressives), $65 (trifocals).	For vision coverage through Vision Service Plan (VSP), call 1-855-866-0942 for benefit information. Lenses and frames limited to once every 24 months. Charges apply for lens add-ons and premium progressive lenses.
	Children's dental check-up	Not covered	Not covered	You may have other dental coverage not described here

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.)

- Chiropractic care
- Cosmetic surgery
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)		
• Acupuncture (plan provider referred) • Bariatric surgery	• Dental care (Adult) (available through separate standalone plan) • Infertility treatment	• Routine eye care (Adult) (limited benefit for frames/lenses available through VSP)

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.healthhelp.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).]

[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, kwiijigo 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 plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Other (blood work) 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)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$60

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Other (blood work) copayment	$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)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$320

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Other (x-ray) copayment	$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)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$50
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$450

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