

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 <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 deductible?	\$100 Individual / \$200 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$3,000 Individual / \$6,000 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 out-of-pocket limit?	<u>Premiums</u> , and health care this <u>plan</u> doesn't cover, and services indicated in 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 network provider?	Yes. See www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of <u>network providers</u> . For a list of chemical dependency providers, call Assistance & Recovery Program (ARP) at 1-800-562-3277.	This <u>plan</u> uses a <u>provider 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 <u>provider's charge</u> 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 referral to see a specialist?	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
		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, <u>deductible</u> does not apply.	Not covered	None
	<u>Specialist</u> visit	\$15 / visit, <u>deductible</u> does not apply.	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$10 / encounter, <u>deductible</u> does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> up to \$50 / procedure	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/formulary	Generic drugs	Retail: \$10 / <u>prescription</u> ; Mail order: \$20 / <u>prescription</u> . <u>Deductible</u> does not apply.	Not covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <u>formulary</u> guidelines. No Charge for Contraceptives, <u>deductible</u> does not apply.
	Preferred brand drugs	Retail: \$30 / <u>prescription</u> ; Mail order: \$60 / <u>prescription</u> . <u>deductible</u> does not apply.	Not covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <u>formulary</u> guidelines. No Charge for Contraceptives, <u>deductible</u> does not apply.
	Non-preferred brand drugs	Same as preferred brand drugs	Not covered	Same as preferred brand drugs when approved through exception process.
	<u>Specialty drugs</u>	20% <u>coinsurance</u> up to \$200 / <u>prescription</u> , <u>deductible</u> does not apply.	Not covered	Up to 30-day supply retail. Subject to <u>formulary</u> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	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)	
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	None
	<u>Emergency medical transportation</u>	\$150 / trip	\$150 / trip	None
	<u>Urgent care</u>	\$15 / visit, <u>deductible</u> does not apply.	\$15 / visit, <u>deductible</u> does not apply.	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	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 mental health, behavioral health, or substance abuse services	Outpatient services	Kaiser: Mental / Behavioral Health: \$15 / individual visit, <u>deductible</u> does not apply. 20% <u>coinsurance</u> for other outpatient services; Substance Abuse: \$15 / individual visit, <u>deductible</u> does not apply. 20% <u>coinsurance</u> up to \$5 / day for other outpatient services, <u>deductible</u> does not apply. ARP: No charge, <u>deductible</u> does not apply.	Kaiser and ARP: Not Covered	Kaiser: Mental / Behavioral Health: \$7 / group visit; Substance Abuse: \$5 / group visit. ARP: These supplemental chemical dependency benefits are for the employee and spouse only.
	Inpatient services	Kaiser: 20% <u>coinsurance</u> ARP: No charge, <u>deductible</u> does not apply.	Kaiser and ARP: Not Covered	Kaiser: Medical detox should be coordinated with your Kaiser PCP. ARP: These supplemental chemical dependency benefits are for the employee and spouse only. Elective hospitalization at an ARP facility requires <u>preauthorization</u> to avoid a \$300 penalty.
If you are pregnant	Office visits	No charge, <u>deductible</u> does not apply.	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	20% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge, <u>deductible</u> does not apply.	Not covered	Up to 2 hour limit / visit, up to 3 visit limit / day, up to 100 visit limit / year
	<u>Rehabilitation services</u>	Inpatient: 20% <u>coinsurance</u> ; Outpatient: \$15 / visit	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)	
	<u>Habilitation services</u>	\$15 / visit	Not covered	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	Up to 100 day limit maximum / benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not covered	Subject to <u>formulary</u> guidelines. Requires prior authorization.
	<u>Hospice services</u>	No charge, <u>deductible</u> does not apply.	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge, <u>deductible</u> does not apply.	Not covered	If your employer elects to include the optional vision <u>plan</u> , it will be through a separate VSP policy.
	Children's glasses	No covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If your employer elects to include the optional dental <u>plan</u> , it will be through a separate Delta Dental policy.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Children's glasses • Chiropractic care • Cosmetic surgery • Dental care (Adult & Child) (may be available through separate dental <u>plan</u>) 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S 	<ul style="list-style-type: none"> • 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture (plan provider referred) • Bariatric surgery 	<ul style="list-style-type: none"> • Hearing aids (payable through the Trust Fund) • Infertility treatment 	<ul style="list-style-type: none"> • Routine eye care (Adult) (additional benefits may be available through separate vision <u>plan</u>)

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 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

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 plan's overall deductible** **\$100**
- **Specialist copayment** **\$15**
- **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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$100
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

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

- **The plan's overall deductible** **\$100**
- **Specialist copayment** **\$15**
- **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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Joe would pay is	\$1,250

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

- **The plan's overall deductible** **\$100**
- **Specialist copayment** **\$15**
- **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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$500

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. A grievance includes a complaint or an appeal. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage or Certificate of Insurance*, or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, Medi-Cal, MRMP, Medi-Cal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at

<http://www.hhs.gov/ocr/office/file/index.html>.

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros (Member Service Contact Center) brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Una queja incluye una queja formal o una apelación. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros (Member Services) para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, Medi-Cal, MRMIP (Mayor Risk Medical Insurance Program, Programa de Seguro Médico para Riesgos Mayores), Medi-Cal Access, FEHBP (Federal Employees Health Benefits Program, Programa de Beneficios Médicos para los Empleados Federales) o CalPERS ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U. S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civiles, en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.

Kaiser Permanente禁止以年齡、種族、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達方式、性取向、婚姻狀況、生理或心理殘障、支付來源、遺傳資訊、公民身份、主要語言或移民身份為由而對任何人進行歧視。

計畫成員服務聯絡中心提供語言協助服務；每週七天24小時晝夜服務（法定節假日除外）。本機構在全部辦公時間內免費為您提供口譯服務，其中包括手語。我們還可為您、您的親屬和朋友提供任何必要的特別補助，以便您使用本機構的設施與服務。此外，您還可請求以您的語言提供健康保險計畫資料之譯本，並可請求採用大號字體或其他版本格式提供此類資料的譯本，藉以滿足您的需求。若需詳細資訊，請致電**1-800-757-7585**（TTY專線使用者請撥**711**）。

冤情申訴係指您或您的授權代表透過冤情申訴程序所表達的不滿陳訴。申訴冤情包括投訴或上訴。例如，如果您認為自己受到本機構的歧視，則可提出冤情申訴。若需瞭解可供您選擇的適用戶議解決方案，請參閱您的：《保險計畫承保項目說明書》或《保險證明書》，或者與計畫成員服務代表交談。對於Medicare、Medi-Cal、MRMIP、Medi-Cal Access、FEHBP或CalPERS計畫成員，這尤其重要；原因在於，為這些成員提供的爭議解決方案選擇有所不同。

您可透過以下方式提出冤情申訴：

- 於設在本計畫服務設施的某個計畫成員服務處填寫一份《投訴或保險福利索償/請書》（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 將您的冤情申訴書郵寄至設在本計畫服務設施的某個計畫成員服務處（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 致電本機構的計畫成員服務聯絡中心，電話號碼是 **1-800-757-7585**（TTY專線使用者請撥**711**）
- 在本機構的網站上填寫一份冤情申訴書，網址是 **kp.org**

如果您在提交冤情申訴書的過程中需要協助，請致電本機構的計畫成員服務聯絡中心。

涉及種族、膚色、原國籍、性別、年齡或身體殘障歧視的一切冤情申訴都將通告給Kaiser Permanente的民權事務協調員。您也可與Kaiser Permanente的民權服務協調員直接聯絡；聯絡地址是One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以採用電子方式透過民權辦公處的投訴入口網站向美國衛生與公共服務部民權辦公處提出民權投訴，網址是<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>；或者按照如下聯絡資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD專線）。可從網站上下載投訴書，網址是<http://www.hhs.gov/ocr/office/file/index.html>。