**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, visit **www.kp.org**; see the *Summary of Benefits Handbook* at **spd.mypgebenefits.com**; or call Kaiser Northern California **1-800-663-1771**; Southern California **1-800-533-1833**. 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 **https://www.healthcare.gov/sbc-glossary/**.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000** person / **$2,000** family | 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. |
| **Are there services covered before you meet your deductible?** | Yes. Some preventive care, prenatal and postnatal care, some prescription drugs, and hospice services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But 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, but see the Common Medical Events chart below for other costs for services this plan covers. |
| **What is the out-of-pocket limit for this plan?** | **$2,400** person / **$4,800** 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?** | Copayments for certain services, premiums, balance-billing charges, preauthorization penalties for non-compliance, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use an in-network provider?** | Yes. See the Common Medical Events chart below for costs, and visit **www.kp.org** or call Northern California **1-800-663-1771**; Southern California **1-800-533-1833** for a list of in-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 more 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 in-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. | 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 |
|---|---|---|---|---|
| | | In-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 | 10% coinsurance | Not covered | Visits 1–4 covered at 100%; visits 5+ covered at 10% coinsurance; deductible does not apply. |
| | Specialist visit | 20% coinsurance | Not covered | None |
| | Select 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. |
| | Other practitioner office visit | 20% coinsurance for chiropractic and acupuncture | Not covered | Visits 1-5 covered at 10% coinsurance; visits 6+ covered at 20% coinsurance. Care is coordinated by American Specialty Health Network: **1-800-678-9133** (**www.ashcompanies.com**) |
| **If you have a test** | Diagnostic test (X-ray, blood work) | 20% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.kp.org** | Generic drugs | Retail: 15% coinsurance<br>Mail order: 10% coinsurance | Not covered | Up to 100-day supply retail or 100-day supply mail order. No charge for contraceptives subject to formulary guidelines. |
| | Preferred brand drugs | Retail: 25% coinsurance<br>Mail order: 20% coinsurance | Not covered | |
| | Non-preferred brand drugs | Retail: 25% coinsurance<br>Mail order: 20% coinsurance | Not covered | |
| | Specialty drugs | Covered as any other drug | Not covered | Retail and mail order: Up to 100-day supply subject to formulary guidelines. Exceptions apply for drugs for treatment of infertility and sexual dysfunction. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not covered | 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 | 10% coinsurance | 10% coinsurance | Visits 1-4 covered as primary care at 100%; visits 5+ covered at 10% coinsurance; deductible does not apply. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| **If you need mental health, behavioral health, or substance use disorder services** | Outpatient services | 10% coinsurance | Not covered | Deductible does not apply. |
| | Inpatient services | 20% coinsurance | Not covered | **Mental/behavioral health:** Out-of-network emergency admission—authorization required; $300 penalty if you fail to notify Kaiser within 24 hours or as soon as reasonably possible after condition has stabilized. **Substance use disorder:** May use Beacon Health Options or Kaiser for detoxification. All other residential inpatient treatment is available through Beacon Health Options network only, not Kaiser. All Beacon Health Options treatment—including residential inpatient treatment—requires preauthorization; $300 penalty if you fail to notify Beacon Health Options within 48 hours; no limit on number of stays. |
| **If you are pregnant** | Office visits | No charge | Not covered | Deductible does not apply. |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not covered | Nurse visits 2 hours/day; aide visits 4 hours/day; unlimited. |
| | Rehabilitation services | Visits 1–5: 10% coinsurance<br>Visits 6+: 20% coinsurance | Not covered | None |
| | Habilitation services | Visits 1–5: 10% coinsurance<br>Visits 6+: 20% coinsurance | Not covered | None |
| | Skilled nursing care | 20% coinsurance | Not covered | None |
| | Durable medical equipment | 20% coinsurance | Not covered | Must be in accordance with Kaiser's DME formulary guidelines. For specific exclusions, see *What the HAP Doesn't Cover* in the *Summary of Benefits Handbook* at **spd.mypgebenefits.com** (paper copy, pp. 150-156 Management and A&T; pp. 148-154 Union). |
| | Hospice services | No charge | Not covered | Life expectancy of 12 months or less. |
| **If your child needs dental or eye care** | Children's eye exam | 20% coinsurance | 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic Surgery
- Dental Care (Adult & Child)
- Eyeglasses (Adult & Child)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- 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
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (1 per ear every 3 years)
- Infertility Treatment ($7,000 limit/lifetime)
- Private-Duty Nursing when medically necessary

**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: The plan—Northern California **1-800-663-1771**; Southern California **1-800-533-1833**; your state insurance department; or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272**) or **www.dol.gov/ebsa/healthreform.** 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 following: **Medical Appeals** Kaiser Permanente Insurance Company—Appeals, 3701 Boardman-Canfield Road, Canfield, OH 44406 / Northern California: **1-800-663-1771** / Southern California: **1-800-533-1833** / Fax: 1-614-212-7110 **www.kp.org**. **Pharmacy Appeals** Kaiser Permanente, Attn: SFAS National Self Funding, 3840 Murphy Canyon Road, San Diego, CA 92123 / Northern California: **1-800-663-1771** / Southern California: **1-800-533-1833** / Fax: 1-858-614-7912 **www.kp.org**. You may also contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or **www.dol.gov/ebsa/healthreform**.

**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 1-800-964-0530.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-964-0530.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-964-0530.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-964-0530.

Your health benefits will be self-insured by your plan sponsor. Kaiser Permanente Insurance Company will provide certain administrative services for the plan and will not be an insurer of the plan or financially liable for health care benefits under the plan.

*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 (single) coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,000* |
| Specialist (prenatal) coinsurance | No charge |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |
| Out-of-pocket limit** | $2,400 |

**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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductible* | $1,000 |
| Copayments | N/A |
| Coinsurance | $2,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,460**** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000* |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |
| Out-of-pocket limit** | $2,400 |

**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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductible* | $1,000 |
| Copayments | N/A |
| Coinsurance | $1,600 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Joe would pay is** | **$2,470**** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000* |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |
| Out-of-pocket limit** | $2,400 |

**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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductible* | $1,000 |
| Copayments | N/A |
| Coinsurance | $180 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,180** |

*If you earn maximum Health Account credits ($1,000 per year), you'll have enough Health Account credits to pay your annual deductible. For information about the Health Account, see **mypgebenefits.com**. **If you reach the annual out-of-pocket limit ($2,400/single coverage or $4,800/family coverage), the Kaiser HAP will pay 100% of your covered costs for the rest of the year. The annual out-of-pocket limit includes amounts you pay toward your deductible. It **does not include** penalty charges, amounts that exceed the reasonable and customary amounts for out-of-network charges, or charges for services that aren't covered.

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