




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 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 healthcare.gov/sbc-glossary or call Kaiser at one of the numbers listed above to request a copy.

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 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 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% <u>coinsurance</u>	Not covered	Visits 1–4 covered at 100%; visits 5+ covered at 10% <u>coinsurance</u> ; <u>deductible</u> does not apply.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	Not covered	None
	Select <u>preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	Other practitioner office visit	20% <u>coinsurance</u> for chiropractic and acupuncture	Not covered	Visits 1-5 covered at 10% <u>coinsurance</u> ; visits 6+ covered at 20% <u>coinsurance</u> . Care is coordinated by American Specialty Health Network: 1-800-678-9133 (ashcompanies.com)
If you have a test	<u>Diagnostic test</u> (X-ray, blood work)	20% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at kp.org	Generic drugs	Retail: 15% <u>coinsurance</u> Mail order: 10% <u>coinsurance</u>	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% <u>coinsurance</u> Mail order: 20% <u>coinsurance</u>	Not covered	
	Non-preferred brand drugs	Retail: 25% <u>coinsurance</u> Mail order: 20% <u>coinsurance</u>	Not covered	
	<u>Specialty drugs</u>	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% <u>coinsurance</u>	Not covered	None
	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>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Visits 1-4 covered as primary care at 100%; visits 5+ covered at 10% <u>coinsurance</u> ; <u>deductible</u> 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% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	10% <u>coinsurance</u>	Not covered	<u>Deductible</u> does not apply.
	Inpatient services	20% <u>coinsurance</u>	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 <u>preauthorization</u> ; \$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	<u>Deductible</u> does not apply.
	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>	20% <u>coinsurance</u>	Not covered	Nurse visits 2 hours/day; aide visits 4 hours/day; unlimited.
	<u>Rehabilitation services</u>	Visits 1–5: 10% <u>coinsurance</u> Visits 6+: 20% <u>coinsurance</u>	Not covered	None
	<u>Habilitation services</u>	Visits 1–5: 10% <u>coinsurance</u> Visits 6+: 20% <u>coinsurance</u>	Not covered	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	None
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Must be in accordance with Kaiser's DME <u>formulary</u> guidelines. For specific exclusions, see <i>What the HAP Doesn't Cover</i> in the <i>Summary of Benefits Handbook</i> at spd.mypgebenefits.com (paper copy, pp. 150-156 Management and A&T; pp. 148-154 Union 2014 edition).
	<u>Hospice services</u>	No charge	Not covered	Life expectancy of 12 months or less.
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	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 <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Cosmetic Surgery• Dental Care (Adult & Child)• Eyeglasses (Adult & Child)	<ul style="list-style-type: none">• Long-Term Care• Non-emergency care when traveling outside the U.S.• Routine Eye Care (Adult)	<ul style="list-style-type: none">• 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• Bariatric Surgery	<ul style="list-style-type: none">• Chiropractic Care• Hearing Aids (1 per ear every 3 years)	<ul style="list-style-type: none">• 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 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 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 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 kp.org. You may also contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

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, kwijigo 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 <u>plan's overall deductible</u>	\$1,000*
■ <u>Specialist (prenatal) coinsurance</u>	No charge
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%
■ <u>Out-of-pocket limit**</u>	\$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductible*	\$1,000
Copayments	N/A
Coinsurance	\$2,300
<i>What isn't covered</i>	
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 <u>plan's overall deductible</u>	\$1,000*
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%
■ <u>Out-of-pocket limit**</u>	\$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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductible*	\$1,000
Copayments	N/A
Coinsurance	\$1,600
<i>What isn't covered</i>	
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 <u>plan's overall deductible</u>	\$1,000*
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%
■ <u>Out-of-pocket limit**</u>	\$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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductible*	\$1,000
Copayments	N/A
Coinsurance	\$180
<i>What isn't covered</i>	
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 myggebenefits.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.