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?	For covered medical services obtained at Kaiser: $1,500 Individual / $3,000 Family The **Prescription Drug** and Ancillary Benefits OOP Limit (applicable to network prescription drug copays, expenses for injectable drugs not provided by Kaiser, and chiropractic/acupuncture not provided by Kaiser): $7,600 Individual / $15,200 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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	***For medical services obtained from Kaiser:*** services indicated in the chart starting on page 2, health care not covered by Kaiser. ***The Prescription Drug and Ancillary Benefits OOP limit:*** expenses for non-formulary drugs without a PBM-approved medical exception and services and supplies from a Kaiser provider. All: Premiums, balance billing charges, and health care this plan doesn't cover are not included in either out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
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	$25 / visit	Not Covered	None
	Specialist visit	$35 / 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
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Formulary generic drugs	$10 copay per prescription ($7 for certain maintenance drugs).	Not covered except for an emergency. Emergency benefits: you pay applicable copay plus $25 and any charges above the allowed amount.	Coverage by the Prescription Drug Program offered through Caremark. Copays shown are for a 30-day supply. Up to 90-day supply can be obtained for 2 copays. Limited Kaiser coverage provided for drugs through Kaiser facility. Emergency benefits for out-of-network pharmacies: you pay applicable copay plus $25 and any balance billing. Plan pays the lesser of purchase price or average wholesale price (AWP), less applicable copay(s). No charge for ACA-required preventive care drugs (usually generic, with some exceptions if a generic is medically inappropriate) purchased at a network pharmacy with a prescription from a physician.
	Formulary brand drugs	$20 copay per prescription ($15 for certain maintenance drugs).		
	Non-formulary generic or brand drugs	$35 copay per prescription ($25 for certain maintenance drugs).		
	Injectable drugs	No Charge	Not Covered	Injectables not covered by Kaiser may be covered by Fund. If covered by the Fund, you pay 20% coinsurance plus any charges above the allowed amount.

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)	$150 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	$100 / visit	$100/ visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$25 / visit	$25 / visit	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission	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: $25 / individual visit. No charge for other outpatient services Substance Abuse: $25 / individual visit. $5 / day for other outpatient services	Not Covered	Mental / Behavioral health: $12 / group visit. Substance Abuse: $5 / group visit.
	Inpatient services	$500 / admission	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	$500 / admission	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: $500 / admission Outpatient: $25 / visit	Not Covered	None
	Habilitation services	$25 / visit	Not Covered	None
	Skilled nursing care	$500 / admission	Not Covered	Up to 100 days maximum / benefit period.
	Durable medical equipment	No Charge	Not Covered	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	Additional benefits available through the Fund's separate vision program.
	Children's glasses	Not Covered	Not Covered	Limited benefit may be available from the Fund's separate vision program.
	Children's dental check-up	Not Covered	Not Covered	Benefits available through the Fund's separate Indemnity Dental Plan or Prepaid Dental Plan.

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.)

- Children's glasses (benefits may be available through the Fund's separate vision program)
- Cosmetic surgery
- Dental care (Adult and child) (coverage under separate Indemnity Dental Plan or Prepaid Dental Plan)
- Infertility treatment
- 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 (Kaiser provider referred. Also, limited Fund benefit of up to $1,000 combined with chiropractic)
- Bariatric surgery
- Chiropractic care (Fund provided benefit with annual limit of $1,000 combined with Fund covered acupuncture.)
- Hearing aids ($1000 limit/ear / 36 months)
- Routine eye care (Adult) (Fund provides additional benefit limited to $200/year)

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)

***** The outpatient Prescription Drug Benefit is offered separately by the UFCW Unions and Food Employers Benefit Fund and is not part of the Kaiser Permanente medical plan offering. Please contact the Fund at 877-284-2320 for any questions regarding your pharmacy benefit.***

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	**$35**
Hospital (facility) copayment	**$500**
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	$510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$530**

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	**$35**
Hospital (facility) copayment	**$500**
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	$760
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$760**

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

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$500**
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	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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