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?	$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?	N/A	There is no deductible.
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?	**$1,500** person / **$3,000** 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?	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. Except for emergency room services and urgent care, out-of-network services are not covered. 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 copay/visit	Not covered	None
	Specialist visit	$10 copay/visit	Not covered	None
	Select preventive care/screening/ immunization	Preventive care screenings $10 copay; preventive immunizations no charge	Not covered	Does not apply to out-of-pocket limit. 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	$10 copay/visit	Not covered	**Chiropractic visits:** Self-referral allowed; no preauthorization needed **Acupuncture visits:** Referral required from a Kaiser physician
If you have a test	Diagnostic test (X-ray, blood work)	No charge	Not covered	Does not apply to out-of-pocket limit.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Does not apply to out-of-pocket limit.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **kp.org**	Generic drugs	$10 copay	Not covered	Up to 100-day supply; does not apply to out-of-pocket limit.
	Preferred brand drugs	$10 copay	Not covered	Up to 100-day supply; does not apply to out-of-pocket limit.
	Non-preferred brand drugs	$10 copay	Not covered	Up to 100-day supply; does not apply to out-of-pocket limit.
	Specialty drugs	$10 copay	Not covered	Up to 100-day supply; 50% coinsurance for drugs for treatment of infertility and sexual dysfunction; memory enhancement drugs not covered. Does not apply to out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 copay	Not covered	None
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	$25 copay/visit	$25 copay/visit	Waived if admitted as an inpatient.
	Emergency medical transportation	No charge	No charge	Does not apply to out-of-pocket limit.
	Urgent care	$10 copay/visit	$10 copay/visit	Non-plan providers covered when temporarily outside the service area.

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)	No charge	Not covered	None
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$10/individual visit	Not covered	$5/group visit
	Inpatient services	No charge	Not covered	**Substance use disorder:** May use Beacon Health Options (BHO) or Kaiser for detoxification. All other residential inpatient treatment is available through BHO network only, not Kaiser. All BHO treatment—including residential inpatient treatment—requires preauthorization; $300 penalty if you fail to notify BHO within 48 hours; no limit on number of stays. Does not apply to out-of-pocket limit.
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in this document. Does not apply to out-of-pocket limit.
	Childbirth/delivery professional services	Included in facility fee	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	Does not apply to out-of-pocket limit.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	3 visits/day; 100 visits/calendar year. Does not apply to out-of-pocket limit.
	Rehabilitation services	$10 copay	Not covered	None
	Habilitation services	$10 copay	Not covered	None
	Skilled nursing care	No charge	Not covered	100 days/calendar year. Does not apply to out-of-pocket limit.
	Durable medical equipment	No charge	Not covered	Must be in accordance with Kaiser's DME formulary guidelines. Does not apply to out-of-pocket limit. For specific exclusions, see p. 44 of the Kaiser EPO Summary Plan Description (call Kaiser to request a copy).
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	$10 copay	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	• Long-Term Care	• Routine Eye Care (Adult)
• Dental Care (Adult & Child)	• Non-emergency care when traveling outside the U.S.	• Routine Foot Care
• Eyeglasses (Adult & Child)	• Private-Duty Nursing	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (medically referred)	• Chiropractic Care (self-referred)	• Infertility Treatment
• Bariatric Surgery	• Hearing Aids (1 per ear every 3 years)	

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, 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** $0
- **Specialist (prenatal) copayment** $0
- **Hospital (facility) copayment** $0
- **Other copayments** $10
- **Out-of-pocket limit*** $1,500

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	N/A
Copayments	$130
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$190**

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** $10
- **Hospital (facility) copayment** $0
- **Other copayments** $10
- **Out-of-pocket limit*** $1,500

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	N/A
Copayments	$580
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$640**

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

- **The plan's overall deductible** $0
- **Specialist copayment** $10
- **Hospital (facility) copayment** $0
- **Other copayments** $10
- **Out-of-pocket limit*** $1,500

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	N/A
Copayments	$70
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$70**

*If you reach the annual out-of-pocket limit ($1,500/single coverage or $3,000/family coverage), the Kaiser EPO 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.