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 1-888-865-5813 (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 https:/healthcare.gov/sbc-glossary or call 1-800-922-1613 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250**/individual; **$750**/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. Preventive services, prescription drugs, physician office visits, dental or vision services except those covered under major medical 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 a copayment or coinsurance may apply. For example, the plan covers certain preventive services without cost-sharing and before your 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?	Yes. **$50**/individual for pediatric dental. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$6,350**/individual, **$12,700**/family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, dental services except those covered under HMO medical benefits, 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 a network provider?	Yes. See www.kp.org or call 1-888-865-5813 (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 non-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 a non-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	$20 copay/visit. Deductible does not apply	Not Covered	None
	Specialist visit	$35 copay/visit. Deductible does not apply	Not Covered	None
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% 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	At Kaiser: $10 copay/script At Network Pharmacy: $20 copay/script At Home Delivery: $20 copay/script Deductible does not apply.	Not Covered	Covers up to 30-day supply at retail; 31-90 day supply at mail order. Network Pharmacies limited to one-time fill, refills must be through Kaiser. No charge for contraceptives (subject to formulary guidelines).
	Preferred brand name drugs	At Kaiser: $25 copay/script At Network Pharmacy: $35 copay/script At Home Delivery: $50 copay/script Deductible does not apply.	Not Covered	Covers up to 30-day supply at retail; 31-90 day supply at mail order. Network Pharmacies limited to one-time fill, refills must be through Kaiser.
	Non-preferred brand name drugs	Not Covered	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	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 immediate medical attention	Emergency room care	$100 copay, then 30% coinsurance	$100 copay, then 30% coinsurance	$100 copay/visit waived if admitted to hospital from emergency room
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	Not Covered	Non-Plan provider urgent care covered only if you are temporarily outside of Kaiser service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/Behavioral health: $20 copay/visit (individual) $10 copay/visit (group) Deductible does not apply. Substance abuse: Not Covered	Not Covered	Charges related to substance abuse services are not covered.
	Inpatient services	Mental/Behavioral health: 30% coinsurance Substance abuse: Not Covered	Not Covered	Charges related to substance abuse services are not covered.
If you are pregnant	Office visits	No Charge. Deductible does not apply.	Not Covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Coverage is limited to 1 Postnatal visit. Depending on the type of services, copayment, coinsurance and deductible may apply to office visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not Covered	None
	Childbirth/delivery facility services	30% coinsurance	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	30% coinsurance	Not Covered	Private duty nursing not covered.
	Rehabilitation services	30% coinsurance	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	30% coinsurance	Not Covered	None
	Durable medical equipment	30% coinsurance	Not Covered	Coverage is limited to items on DME formulary.
	Hospice services	30% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge Deductible does not apply	Not Covered	None
	Children's glasses	No Charge Deductible does not apply	Not Covered	Limited to $200 credit every 2 years for glasses.
	Children's dental check-up	No Charge Deductible does not apply	No Charge Deductible does not apply.	Coverage provided through Cigna. Limited to 1 exam/6 months.

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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aids
- Infertility treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Substance abuse services
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care, limited to 26 visits/year
- Dental care (adult), limited to $100/year
- Routine eye care (Adult), hardware limited to $200 credit/2 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 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 agency in the charge below:

Your Grievance and Appeals Rights

Kaiser Permanente Member Services	1-888-865-5813 (TTY: 711) or www.kp.org/memberservices
Cigna Healthcare (for dental benefits only)	1-800-CIGNA24 (244-6224) or www.myCigna.com
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
Georgia Department of Insurance (for Kaiser HMO benefits only)	1-800-656-2298 or www.oci.ga.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 1-888-865-5813 (TTY: 711)

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-865-5813 (TTY: 711)

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-888-865-5813 (TTY: 711)

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-865-5813 (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	$250
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	
Deductibles	$250
Copayments	$35
Coinsurance	$3,755
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,100**

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

The plan's overall deductible	$250
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	
Deductibles	$200
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$1,350**

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

The plan's overall deductible	$250
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	
Deductibles*	$250
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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