



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- 866-213-3062 or 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 1-877-356-5092 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,500 Individual / \$5,000 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, preventive services and services indicated in chart starting on page 2.	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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	\$4,000 Individual/ \$8,000 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?	Premiums , balanced-billed charges 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 1-866-213-3062 or TTY 711 for a list of plan 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 specialist .	You can see the specialist you choose without a referral .

 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
		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	20% Coinsurance	Not Covered	None
	Specialist visit	20% Coinsurance	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)	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	20% coinsurance (retail & mail order) / prescription	Not Covered	Up to a 100-day supply (retail & mail order). No charge, deductible does not apply for contraceptives. Subject to formulary guidelines.
	Preferred brand drugs	20% coinsurance (retail & mail order) / prescription	Not Covered	Up to a 100-day supply (retail & mail order). Subject to formulary guidelines.
	Non-preferred brand drugs	Same as Preferred brand drugs	Not Covered	Up to a 100-day supply (retail & mail order). Subject to formulary guidelines, when approved through the exception process.
	Specialty drugs	Same as Preferred brand drugs	Not Covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.
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	Emergency room care	20% Coinsurance	20% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
medical attention	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	Not Covered	Non-Plan providers covered when temporarily outside the service area.: 20% coinsurance
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 abuse services	Outpatient services	20% Coinsurance	Not Covered	None
	Inpatient services	20% Coinsurance	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	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	No charge	Not Covered	2-hour limit / visit, 3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient services: 20% Coinsurance Outpatient services: 20% Coinsurance	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days / condition / year. Outpatient: 60 visit limit combined / therapy / year (autism spectrum disorders are not subject to the visit limit).
	Habilitation services	20% Coinsurance	Not Covered	Outpatient: 60 visit limit combined / therapy year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% Coinsurance	Not Covered	100 day limit / year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% Coinsurance	Not Covered	Prior authorization required.
	Hospice services	No charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam, deductible does not apply.	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 .)		
<ul style="list-style-type: none"> Children's glasses Cosmetic Surgery Dental care (Adult and child) 	<ul style="list-style-type: none"> Hearing Aids Long Term Care/Custodial Nursing Home Care Non-emergency care when traveling outside the US 	<ul style="list-style-type: none"> Private-duty nursing Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Acupuncture (plan provider referred) Chiropractic care 	<ul style="list-style-type: none"> Infertility treatment (Covered through Progyny) Fertility treatments are administered through Progyny. Please call (833) 233-1395 to activate benefit. 	<ul style="list-style-type: none"> Routine eye care (Adult) Weight Loss Programs

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:

Self-Funded Customer Service	1-800-788-0710 (TTY: 711)
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

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 1-866-213-3062 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-213-3062 (TTY: 711)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-213-3062 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-213-3062 (TTY: 711)

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 coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist Coinsurance](#) 20%
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Peg would pay is	\$3,550

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist Coinsurance](#) 20%
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,100

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist Coinsurance](#) 20%
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,700

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call: **1-866-213-3062** (TTY: **711**)

If you believe that KPIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: KPIC Civil Rights Coordinator, 3701 Boardman-Canfield Rd, Canfield OH 44406, telephone number 1-866-213-3062.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-866-213-3062** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-866-213-3062** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-213-3062** (TTY: **711**).

Հայերեն (Armenian): Ուժեղագույնը թույլ է տալիս անհատներին, որոնք խոսում են հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ձանգահարեք **1-866-213-3062** (TTY **711**):

Bàsóò Wùdù (Bassa) Dè dɛ nìà kɛ dyédé gbo: ɔ jũ ké m̀ Bàsóò-wùdù-po-nyò jũ ní, níí, à wuɖu kà kò dò po-poò b̀éìn m̀ gbo kpáa. Đá **1-866-213-3062** (TTY: 711)

বাংলা (Bengali) লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-866-213-3062** (TTY: 711)।

中文 (Chinese) 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 **1-866-213-3062** (TTY: 711)。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-866-213-3062** تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-866-213-3062** (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-866-213-3062** (TTY: 711).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-866-213-3062** (TTY: 711).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-213-3062** (TTY: 711).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-866-213-3062** (TTY: 711) पर कॉल करें।

Hmoob (Hmong) CEEB TOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, uas pab dawb rau koj. Hu rau **1-866-213-3062** (TTY: 711).

Igbo (Igbo) NRUBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dijirị gi. Kpọọ **1-866-213-3062** (TTY: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-866-213-3062** (TTY: 711).

日本語 (Japanese) 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。 **1-866-213-3062** (TTY: 711) まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អ្លួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-866-213-3062** (TTY: 711)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-866-213-3062** (TTY: 711) 번으로 전화해 주십시오.

ລາວ (Laotian) ໄປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການ ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ **1-866-213-3062** (TTY: 711).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yánífti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jii'eh, éí ná hóló, koji' hódíílnih **1-866-213-3062** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-866-213-3062** (TTY: 711) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-866-213-3062** (TTY: 711).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-866-213-3062** (TTY: 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-866-213-3062** (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-866-213-3062** (TTY: 711).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-866-213-3062** (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-213-3062** (TTY: 711).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-213-3062** (TTY: 711).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-866-213-3062** (TTY: 711).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-866-213-3062** (TTY: 711).

اردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1-866-213-3062** (TTY: 711)۔

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-866-213-3062** (TTY: 711).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-866-213-3062** (TTY: 711).