



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](http://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](http://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?	\$2,000 Self only enrollment, \$2,700 for any one member within a Family enrollment, \$4,000 for an entire 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 care 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.
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?	\$3,000 Self only enrollment, \$3,000 for any one member within a Family enrollment, \$6,000 for an entire 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, health care this plan doesn't cover, and services indicated in chart starting on page 2.	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 <a href="http://www.kp.org">www.kp.org</a> 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 providers 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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$30 / visit	Not Covered	None
	<u>Specialist</u> visit	\$30 / visit	Not Covered	None
	<u>Preventive care/ screening/ immunization</u>	No Charge, <u>deductible</u> does not apply.	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	\$50 / procedure	Not Covered	None
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> .	Generic drugs	Retail: \$10 / prescription; Mail order: \$20 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <u>formulary</u> guidelines. No Charge for Contraceptives, <u>deductible</u> does not apply.
	Preferred brand drugs	Retail: \$30 / prescription; Mail order: \$60 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <u>formulary</u> guidelines. No Charge for Contraceptives, <u>deductible</u> does not apply.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	<u>Specialty</u> drugs	20% <u>coinsurance</u> up to \$150 / prescription	Not Covered	Up to a 30-day supply retail. Subject to <u>formulary</u> guidelines.
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

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	None
	<u>Emergency medical transportation</u>	\$100 / trip	\$100 / trip	None
	<u>Urgent care</u>	\$30 / visit	\$30 / visit	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 / admission	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral Health: \$30 / individual visit. No Charge for other outpatient services; Substance Abuse: \$30 / individual visit. \$5 / day for other outpatient services	Not Covered	Mental / Behavioral Health: \$15 / group visit; Substance Abuse: \$5 / group visit.
	Inpatient services	\$250 / admission	Not Covered	None
If you are pregnant	Office visits	No Charge, <u>deductible</u> does not apply.	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> 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	\$250 / admission	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	<a href="#">Rehabilitation services</a>	Inpatient: \$250 / admission; Outpatient: \$30 / visit	Not Covered	None
	<a href="#">Habilitation services</a>	\$30 / visit	Not Covered	None
	<a href="#">Skilled nursing care</a>	\$250 / admission	Not Covered	Up to 100 days maximum / benefit period.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not Covered	Subject to <a href="#">formulary guidelines</a> . Requires prior authorization.
	<a href="#">Hospice service</a>	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	<b>Kaiser:</b> \$30 / visit, <a href="#">deductible</a> does not apply. <b>VSP:</b> \$5 <a href="#">copayment/exam</a> , <a href="#">Deductible</a> does not apply.	<b>Kaiser:</b> Not Covered <b>VSP:</b> \$5 <a href="#">copayment/exam</a> , up to \$45, plus any <a href="#">balance billing</a> charges. <a href="#">Deductible</a> does not apply.	If elected, additional vision coverage is available under separate <a href="#">vision plan</a> through VSP.
	Children's glasses	<b>Kaiser:</b> Not Covered <b>VSP:</b> No charge for lenses, no charge up to a \$150 allowance for frames (\$170 allowance for featured brand frames), then 100% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	<b>Kaiser:</b> Not Covered <b>VSP:</b> No charge, up to a \$70 allowance for frames and a \$30 allowance for lenses, then 100% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> charges. <a href="#">Deductible</a> does not apply.	If elected, vision coverage is available under separate <a href="#">vision plan</a> through VSP. Some types of lenses may be eligible for a higher allowance.
	Children's dental check-up	<b>Kaiser:</b> Not Covered <b>Premier Access:</b> No charge. <a href="#">Deductible</a> does not apply.	<b>Kaiser:</b> Not Covered <b>Premier Access:</b> Coverage may be available depending on the <a href="#">plan</a> you elect.	If elected, additional coverage is available under separate <a href="#">dental plan</a> .

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a>.)</b>	
<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>
	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan document</a>.)</b>	
<ul style="list-style-type: none"> <li>• Acupuncture (plan provider referred)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult and Child) under separate dental plan.</li> <li>• Hearing aids (available through the Trust Fund)</li> </ul>
	<ul style="list-style-type: none"> <li>• Routine eye care (Adult), additional coverage available under separate vision plan.</li> </ul>

**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 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 <a href="#">www.kp.org/memberservices</a>
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="#">www.dol.gov/ebsa/healthreform</a>
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or <a href="#">www.ccio.cms.gov</a>
California Department of Insurance	1-800-927-HELP (4357) or <a href="#">www.insurance.ca.gov</a>
California Department of Managed Healthcare	1-888-466-2219 or <a href="#">www.healthhelp.ca.gov/</a>

**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 1-800-788-0616 (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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 (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)

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

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

- The plan's overall deductible **\$4,000**
- Specialist copayment **\$30**
- Hospital (facility) copayment **\$250**
- Other (blood work) copayment **\$10**

- The plan's overall deductible **\$2,000**
- Specialist copayment **\$30**
- Hospital (facility) copayment **\$250**
- Other (blood work) copayment **\$10**

- The plan's overall deductible **\$2,000**
- Specialist copayment **\$30**
- Hospital (facility) copayment **\$250**
- Other (x-ray) copayment **\$10**

**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*)

**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*)

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Durable medical equipment (*crutches*)  
Diagnostic test (*x-ray*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
In this example, Peg would pay:					
<b>Cost Sharing</b>		<b>Cost Sharing</b>			
Deductibles	\$4,000	Deductibles	\$2,000	Deductibles	\$1,900
Copays	\$0	Copays	\$800	Copays	\$0
Coinsurance	\$0	Coinsurance	\$200	Coinsurance	\$0
<b>What isn't covered</b>		<b>What isn't covered</b>			
Limits or exclusions	\$60	Limits or exclusions	\$50	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,060</b>	<b>The total Joe would pay is</b>	<b>\$3,050</b>	<b>The total Mia would pay is</b>	<b>\$1,900</b>

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

## Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage* or *Certificate of Insurance*, or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, MediCal, MRMIP, MediCal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at [kp.org](http://kp.org)

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

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 [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://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, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).

## Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, Medi-Cal, el Programa de Seguro Médico para Riesgos Mayores (Major Risk Medical Insurance Program MRMIP), Medi-Cal Access, el Programa de Beneficios Médicos para los Empleados Federales (Federal Employees Health Benefits Program, FEHBP) o CalPERS, ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civil es (Office for Civil Rights Complaint Portal), en [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf) (en inglés) o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html) (en inglés).



## 無歧視公告

Kaiser Permanente 禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週七天 24

小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯，包括手語服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。此外，您還可索取翻譯成您的語言的健康保險計劃資料，以及採用大號字體或其他格式的版本來滿足您的需求。若需更多資訊，請致電 **1-800-757-7585**（TTY 專線使用者請撥 **711**）。

投訴指任何您或您的授權代表透過流程來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出投訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》（*Evidence of Coverage*）或《保險證明書》（*Certificate of Insurance*），或諮詢會員服務代表。如果您是 Medicare、MediCal、MRMIP（Major Risk Medical Insurance Program, 高風險醫療保險計劃）、MediCal Access、FEHBP（Federal Employees Health Benefits Program, 聯邦僱員健康保險計劃）或 CalPERS 會員，向會員服務代表諮詢尤其重要，因為您可能會有不同的爭議解決方式選擇。

您可透過以下途徑投訴：

- 在健康保險計劃服務設施的會員服務處填寫《投訴或福利索賠/申請表》，地址見《健康服務指南》(Your Guidebook)。
- 將書面投訴信郵寄到健康保險計劃服務設施的會員服務處（地址見《健康服務指南》(Your Guidebook)）。
- 給我們的會員服務聯絡中心打免費電話，電話號碼是 **1-800-757-7585**（TTY 專線使用者請撥 **711**）。
- 在我們的網站上填寫投訴表，網址是 **kp.org**

如果您在投訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知 Kaiser Permanente 的民權事務協調員（Civil Rights Coordinator）。您也可與 Kaiser Permanente 的民權事務協調員 直接聯絡，地址：One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以電子方式透過民權辦公室的投訴入口網站向美國健康與公共服務部民權辦公室（U.S. Department of Health and Human Services, Office for Civil Rights）提出民權投訴，網址是 [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf) 或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD 專線）。投訴表可從網站 [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html) 下載。



