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, see the Benefit Booklet for this coverage option or call **1-800-533-1833 (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 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?	$500 Individual or $1,000 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. Some preventive care is covered before you meet your deductible.	This plan covers certain preventive care without cost-sharing and before you meet your deductible. See the Benefit Booklet for more details. The full list of preventive care services is found at https://www.healthcare.gov/coverage/preventive-care-benefits/, but not all of the listed preventive care services are covered by this plan.
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 Individual or $6,000 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 on certain services, premiums, balance-billing 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 1-800-533-1833 (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	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

Important Questions	Answers	Why This Matters:
referral to see a specialist?	as described in the Benefit Booklet.	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
		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 copay/office visit, deductible does not apply	Not covered	$10 copay/group visit
	Specialist visit	$20 copay/office visit, deductible does not apply	Not covered	$10 copay/group visit
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what the plan will pay for because not all preventive care services are paid for by this plan.
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	Not covered	None
	Imaging (CT/PET scans, MRIs)	$10 copay/test	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/formulary After selecting your Region, select "Self-Funded Formulary"	Generic drugs (Tier 1)	$10 copay/prescription (retail); $20 copay/prescription (mail order)	Not covered	Up to a 30-day supply retail or up to 100-day supply mail order. Coverage is subject to formulary guidelines. Contraception drugs and contraceptive devices are not covered.
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail); $60 copay/prescription (mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	If covered, the copay amounts are the same	Not covered	Non-preferred brand name drugs are covered only if allowed under an exception made by a

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)	
		as Tier 1 if a generic and Tier 2 if a brand		physician.
	Specialty drugs (Tier 4)	Copay amounts are the same as Tier 1 if a generic and Tier 2 if a brand	Not covered	Up to a 30-day supply. Coverage is subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	$20 copay for office visits without conscious sedation. 10%/day coinsurance for office visits with conscious sedation
	Physician/surgeon fees	10% coinsurance	Not covered	Physician/surgeon fees are included in the Facility fee
If you need immediate medical attention	Emergency room care	10% coinsurance		None
	Emergency medical transportation	$150 copay/trip		None
	Urgent care	$20 copay/visit, deductible does not apply		Non-Plan providers covered when temporarily outside the service area
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit, deductible does not apply	Not covered	Mental/Behavioral Health: $10 copay/group therapy visit. Chemical Dependency: $5 copay/group therapy visit.
	Inpatient services	Mental/Behavioral health: 10% coinsurance Substance Abuse: $100 copay/admission, deductible does not apply	Not covered	None
If you are pregnant	Office visits	No charge, deductible does not apply	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.

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)	
				ultrasound.)
	Childbirth/delivery professional services	10% coinsurance	Not covered	None
	Childbirth/delivery facility services	10% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge, deductible does not apply	Not covered	3 visits/day; 100 visits/calendar year
	Rehabilitation services	$20 copay/visit, deductible does not apply	Not covered	None
	Habilitation services	$20 copay/visit, deductible does not apply	Not covered	None
	Skilled nursing care	10% coinsurance, deductible does not apply	Not covered	100 days per Plan Year
	Durable medical equipment	20% coinsurance, deductible does not apply	Not covered	None
	Hospice services	No charge, deductible does not apply	Not covered	Hospice services are available for life expectancy of 12 months or less
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	$175 allowance every 24 months
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your Benefit Booklet for more information and a list of any other excluded services.)		
• Alteration or reshaping body structures or tissues (other than reconstructive surgery)	• Eye Surgery	• Religious, personal growth counseling or marriage counseling
• Abortion procedures	• Gender reassignment services	• Sex reassignment services
• Artificial insemination	• Genetic testing	• Sterilization
• Assisted conception services	• Hearing Aids	• Third generation dependents
• Assisted suicide and euthanasia	• Infertility treatment	• Treatments using tissue from aborted fetuses or embryonic cells
• Contraceptives	• Long-term care	• Weight loss programs
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Weight loss drugs used or prescribed for weight loss or weight control
• Dental care (Adult & child)	• Non-medically necessary services	
• Experimental or investigational services	• Private duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Benefit Booklet.)		
• Acupuncture (physician referred; 12 visit limit / year)	• Children's glasses	• Routine eye care
• Bariatric Surgery	• Chiropractic care (limited to 24 visits/year)	• Routine foot care

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:

Reta Customer Service	**1-877-303-7382**
Kaiser Permanente Member Services	1-800-788-0710
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)
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 at 1-866-213-3062 (TTY: 711)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' at 1-866-213-3062 (TTY: 711)
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf at 1-866-213-3062 (TTY: 711) uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-213-3062 (TTY: 711)
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni at 1-866-213-3062 (TTY: 711)
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye at 1-866-213-3062 (TTY: 711)
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang at 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	$500
Specialist Copayments	$20
Hospital (facility) Coinsurance	10%
Other Copayments	$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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,860**

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

The plan's overall deductible	$500
Specialist Copayments	$20
Hospital (facility) Coinsurance	10%
Other Copayments	$10

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	$100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$620**

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

The plan's overall deductible	$500
Specialist Copayments	$20
Hospital (facility) Coinsurance	10%
Other Copayments	$10

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	$500
Copayments	$300
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$890**

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