




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- 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/](http://www.HealthCare.gov/sbc-glossary/) or call 1-866-213-3062 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,000 Individual / \$3,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, <a href="#">preventive services</a> and services indicated in chart starting on page 2.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services, but see the chart starting on page 2 for other costs for services this <a href="#">plan</a> covers.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,000 Individual / \$9,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-866-213-3062 or TTY 711 for a list of <a href="#">plan providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$40 Copay per visit, <a href="#">deductible</a> does not apply; 30% Coinsurance for covered services received during a visit.	Not Covered	None
	<a href="#">Specialist</a> visit	\$60 Copay per visit; 30% Coinsurance for covered services received during a visit.	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge, <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: 30% Coinsurance Lab: No Charge	Not Covered	Diagnostic lab services: not subject to the <a href="#">deductible</a> except when provided in the outpatient department of a hospital; 30% Coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org">www.kp.org</a>	Generic drugs	Retail: \$20 Copay; Mail Order: \$40 Copay	Not Covered	Subject to formulary guidelines. Preventive Drugs on the KP Preventive Drug list at No Charge. Non-preferred brand drugs must be authorized through the non-preferred drug process. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a
	Preferred brand drugs	Retail: \$40 Copay; Mail Order: \$80 Copay	Not Covered	
	Non-preferred brand drugs	Retail: \$60 Copay; Mail Order: \$120 Copay	Not Covered	
	<a href="#">Specialty drugs</a>	20% Coinsurance up to \$250 per drug dispensed retail and mail order prescriptions	Not Covered	

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)	
				30-day supply (retail prescription); 31-90 day supply (mail order prescription).
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
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% Coinsurance	30% Coinsurance	None
	<a href="#">Emergency medical transportation</a>	30% Coinsurance up to \$500, <a href="#">deductible</a> does not apply.	30% Coinsurance up to \$500, <a href="#">deductible</a> does not apply.	None
	<a href="#">Urgent care</a>	\$60 Copay per visit, <a href="#">deductible</a> does not apply; 30% Coinsurance for covered services received during a visit.	\$60 Copay per visit; 30% Coinsurance for covered services received during a visit.	<a href="#">Non-Plan providers</a> covered when temporarily outside the 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	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 Copay per visit, <a href="#">deductible</a> does not apply; 30% Coinsurance for covered services received during a visit.	Not Covered	Group visit 50% of individual visit copay.
	Inpatient services	30% Coinsurance	Not Covered	None
If you are pregnant	Office visits	30% Coinsurance	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% Coinsurance	Not Covered	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)	
	Childbirth/delivery facility services	30% Coinsurance	Not Covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% Coinsurance	Not Covered	Limited to less than 8 hours / day and 28 hours / week.
	<a href="#">Rehabilitation services</a>	Inpatient services: 30% Coinsurance; Outpatient services: \$40 Copay per visit, <a href="#">deductible</a> does not apply	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days / condition / year. Outpatient: 60 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit).
	<a href="#">Habilitation services</a>	\$40 Copay per visit, <a href="#">deductible</a> does not apply	Not Covered	Outpatient: 60 visit limit / therapy year (autism spectrum disorders are not subject to the visit limit).
	<a href="#">Skilled nursing care</a>	30% Coinsurance	Not Covered	100 day limit / year.
	<a href="#">Durable medical equipment</a>	30% Coinsurance	Not Covered	Subject to formulary guidelines. Prosthetic arms and legs at 20% Coinsurance.
	<a href="#">Hospice services</a>	No Charge	Not Covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	\$40 Copay per visit for refractive exam, <a href="#">deductible</a> does not apply; 30% Coinsurance for covered services received during a visit.	Not Covered	For services with an ophthalmologist see "Specialist visit".
	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](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental care (Adult and child)
- Infertility treatment
- Long Term Care/Custodial Nursing Home Care
- Non-emergency care when traveling outside the US
- Routine Foot Care
- 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
- Hearing aids (Up to age 18)
- Private Duty Nursing
- Routine eye care (Adult)

**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](http://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:

Kaiser Permanente Member Services	1-866-213-3062 (TTY: 711) or <a href="http://www.kp.org/cuhealthplan">www.kp.org/cuhealthplan</a>
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">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="http://www.cciio.cms.gov">www.cciio.cms.gov</a>

### 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist Copayments</a>	\$60
■ Hospital (facility) <a href="#">Coinsurance</a>	30%
■ Other <a href="#">Coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist Copayments</a>	\$60
■ Hospital (facility) <a href="#">Coinsurance</a>	30%
■ Other <a href="#">Coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,020</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist Copayments</a>	\$60
■ Hospital (facility) <a href="#">Coinsurance</a>	30%
■ Other <a href="#">Coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$700
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$400
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

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