




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, visit www.cpg.org/mtdocs or call (800) 480-9967. 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.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | Network: \$500 Individual / \$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, for example, network preventive care, emergency room care, urgent care, and certain telehealth services. | 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 preventive services at healthcare.gov/coverage/preventive-care-benefits .** |
| 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 ? | Network: \$3,500 Individual / \$7,000 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 ? | Contributions, (premiums), balance-billing charges, penalties, and healthcare 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 (866) 213-3062 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 referral to see a specialist ? | Yes. | This plan will pay for 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 . |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.cpg.org.

**See Page 5 for important information about telehealth services.

 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 | \$25 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. | Not covered. | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits . |
| 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 have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered. | None. |
| | Physician/surgeon fees | | | |
| If you need immediate medical attention | Emergency room care | 20% coinsurance Deductible does not apply | 20% coinsurance | None. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None. |
| | Urgent care | \$50 copay/visit Deductible does not apply | Not covered. | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered. | Prior authorization is required. |
| | Physician/surgeon fees | | | |

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| 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 need mental health, behavioral health, or substance abuse services | Outpatient services | Individual: \$25 copay/visit Group: \$12 copay/visit Deductible does not apply | Not covered. | None. |
| | Inpatient services | 20% coinsurance | Not covered. | Prior authorization is required. |
| If you are pregnant | Office visits | No charge. | Not covered. | None. |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered. | Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth. |
| | Childbirth/delivery facility services | | | |
| If you need help recovering or have other special health needs | Home health care | No charge. | Not covered. | Includes nurses visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year. Prior authorization is required. |
| | Rehabilitation services | \$25 copay/visit Deductible does not apply | Not covered. | Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies. |
| | Habilitation services | \$25 copay/visit Deductible does not apply | Not covered. | |
| | Skilled nursing care | 20% coinsurance | Not covered. | Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required. |
| | Durable medical equipment | 20% coinsurance Deductible does not apply | Not covered. | None. |
| | Hospice services | No charge. | Not covered. | Prior authorization is required. |
| If your child needs dental or eye care | Children's eye exam | Not covered. | Not covered. | Vision benefits are available through EyeMed Vision Care |
| | Children's glasses | Not covered. | Not covered. | |
| | Children's dental check-up | Not covered. | Not covered. | |

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**See Page 5 for important information about telehealth services.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* |
|---|---------------------------------|--------------------|---|--|
| | | Retail | Mail Order | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org . | Generic drugs | Up to a \$5 copay | Up to a \$5 copay for a 30-day supply; up to a \$10 copay for a 90-day supply | Deductible does not apply. You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery. |
| | Preferred brand drugs | Up to a \$30 copay | Up to a \$30 copay for a 30-day supply; up to a \$60 copay for a 90-day supply | |
| | Non-preferred brand drugs | Up to a \$70 copay | Up to a \$70 copay for a 30-day supply; up to a \$140 copay for a 90-day supply | California residents may receive up to a 100-day supply when using home delivery. No charge for contraceptives. |
| | Specialty drugs | Up to a \$90 copay | Up to a \$90 copay for a 30-day supply | |

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](#).)

| | | |
|--|----------------------------|--|
| • Cosmetic surgery | • Dental care (Adult) | • Long-term care |
| • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) | • Routine foot care (unless related to diabetes or certain other conditions) |
| • Weight loss programs | | |

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

| | | |
|--|---|---|
| • Acupuncture (limit 20 visits per year) | • Bariatric surgery (if Medically Necessary) | • Chiropractic care (limit 20 visits per year) |
| • Hearing aids (limit \$3,000 every three years) | • Infertility treatment (\$50,000 lifetime maximum) | • Private duty nursing (only through home healthcare benefit) |

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**See Page 5 for important information about telehealth services.

Telehealth Services: The Medical Trust will waive all [copays](#), [deductibles](#), and [coinsurance](#) for all telehealth services with a Kaiser Permanente [provider](#).

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements¹. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

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 Kaiser Permanente.

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 (800) 480-9967.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(800) 480-9967.

Pennsylvania Dutch (Deitsch): Fer Hilf griegie in Deitsch, ruf (800) 480-9967 uff.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 480-9967.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

Commented [KA1]: Undelete (except for the "also" near the start of the sentence)

Commented [KA2R1]: For the EPO High only, this technically isn't required under the SBC rules (since there is no deductible being waived as a result of the plan design), but I would suggest including it (1) for informational purposes (re: copays) and (2) for consistency with the others, ease of future updates, etc.

¹ Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

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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 \[cost sharing\]](#) \$35
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$500 |
| Copayments | \$10 |
| Coinsurance | \$2,100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,670 |

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 \[cost sharing\]](#) \$35
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$100 |
| Copayments | \$800 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,120 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist \[cost sharing\]](#) \$35
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$500 |
| Copayments | \$200 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$900 |

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