



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 contribution or [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](http://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](http://www.cpg.org/uniform-glossary) or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$ 2,700/Individual or \$5,450 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 deductible.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, preventive care	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.
Are there other <a href="#">deductibles</a> for specific services?	No.	
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,200 individual / \$8,450 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> ?	Contributions ( <a href="#">Premiums</a> ), <a href="#">balance-billing</a> charges, penalties, and healthcare this <a href="#">plan</a> 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 (866) 213-3062 for a list of <a href="#">network 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> ?	Yes.	The Plan will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have the plan's permission before you see the <a href="#">specialist</a> .

**Questions:** Call 1-866-213-3062 or visit <http://my.kp.org/ecmt>. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.cpg.org/uniform-glossary](http://www.cpg.org/uniform-glossary) or call 1-800-480-9967 to request a copy.

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered.	None.
	<a href="#">Specialist</a> visit	20% coinsurance	Not covered.	
	<a href="#">Preventive care/screening/immunization</a>	No charge.	Not covered.	Preventive care is based on guidelines from the U.S. Preventive Services Task Force, American Cancer Society, The Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. Coverage for child immunizations is based on the published guidelines of the American Academy of Pediatrics. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (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	<a href="#">Emergency room care</a>	20% coinsurance	20% coinsurance	None.
	<a href="#">Emergency medical transportation</a>	20% coinsurance	20% coinsurance	None.
	<a href="#">Urgent care</a>	20% coinsurance	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			

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

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	20% coinsurance	Not covered.	None.
	Inpatient services	20% coinsurance	Not covered.	Prior authorization is required.
If you are pregnant	Office visits	No charge.	Not covered.	None. <a href="#">Deductible</a> does not apply to pre-natal and first post-partum visit.
	Childbirth/delivery professional services	20% coinsurance	Not covered.	Well-newborn care is covered.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge.	Not covered.	Includes nurse visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year.
	<a href="#">Rehabilitation services</a>	20% coinsurance	Not covered.	Benefits include hearing/speech, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	<a href="#">Habilitation services</a>	20% coinsurance	Not covered.	
	<a href="#">Skilled nursing care</a>	20% coinsurance	Not covered.	Limited to 60 days per plan year, combined with acute rehabilitation.
	<a href="#">Durable medical equipment</a>	20% coinsurance	Not covered.	None.
	<a href="#">Hospice services</a>	No charge.	Not covered.	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Additional vision benefits are available through EyeMed Vision Care.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail	Mail Order	
<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	15% coinsurance		You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using the mail order pharmacy. Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% coinsurance		
	<a href="#">Specialty drugs</a>	25% coinsurance		

### 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)	• Hearing aids
• Long-term care	• Non-emergency care when traveling outside the U.S.	• Routine eye care
• Routine foot care	• Weight loss program	

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

• Acupuncture	• Bariatric surgery	• Chiropractic care
• Infertility treatment	• Private-duty nursing	

**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 requirements<sup>1</sup>. 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 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.

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

**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 (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.

[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.*-----

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](#) \$2,700
- [Specialist](#) [cost sharing] 20%
- 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*)

<b>Total Example Cost</b>	<b>\$12,739</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,700
Copayments	\$0
Coinsurance	\$2,525
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,285</b>

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

- The [plan's](#) overall [deductible](#) \$2,700
- [Specialist](#) [cost sharing] 20%
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$950
Copayments	\$1,135
Coinsurance	\$465
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,605</b>

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

- The [plan's](#) overall [deductible](#) \$2,700
- [Specialist](#) [cost sharing] 20%
- 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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$275
Coinsurance	\$215
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$640</b>