



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 1-877-580-6125 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 1-877-580-6125 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$900</b> Individual / <b>\$1,800</b> 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 care</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.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$4,800</b> Individual / <b>\$9,600</b> 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> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.	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/mercercmarketplace">www.kp.org/mercercmarketplace</a> or call 1-877-580-6125 or TTY 711 for a list of <a href="#">plan providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider 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
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: 20% <a href="#">coinsurance</a> Lab: 20% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	None
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs	30% <a href="#">coinsurance</a> with a \$10 minimum / \$20 maximum (retail); 30% <a href="#">coinsurance</a> with a \$25 minimum / \$50 maximum (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply	Not covered	Up to a 30-day supply (retail) or 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines. Federally mandated over the counter items are covered with a prescription. No charge, <a href="#">deductible</a> does not apply for women's <a href="#">preventive</a> contraceptives, in accordance with <a href="#">formulary</a> guidelines.
	Preferred brand drugs	30% <a href="#">coinsurance</a> with a \$25 minimum / \$50 maximum (retail); 30% <a href="#">coinsurance</a> with a \$62.50 minimum / \$125 maximum (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply	Not covered	Up to a 30-day supply (retail) or 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines. Federally mandated over the counter items are covered with a prescription. No charge, <a href="#">deductible</a> does not apply for women's <a href="#">preventive</a> contraceptives, in accordance with <a href="#">formulary</a> guidelines.
	Non-preferred brand drugs	45% <a href="#">coinsurance</a> with a \$40 minimum / \$80 maximum (retail); 45% <a href="#">coinsurance</a> with a \$100 minimum / \$200 maximum (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply	Not covered	Up to a 30-day supply (retail) or 90-day supply (mail order). No charge, <a href="#">deductible</a> does not apply for contraceptives. Subject to <a href="#">formulary</a> guidelines, when approved through exception process.
	<a href="#">Specialty drugs</a>	Applicable Generic, Preferred brand or Non-preferred brand <a href="#">cost shares</a> may apply.	Not covered	Up to a 30-day supply (retail) or 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Non-Plan providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Not covered	None
	Inpatient services	20% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	20% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	Not covered	Limited to less than 8 hours / day and 28 hours / week. 120 visit limit / year.
	<a href="#">Rehabilitation services</a>	Outpatient: 20% <u>coinsurance</u> Inpatient: 20% <u>coinsurance</u>	Not covered	None
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	Not covered	None
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	Not covered	120 day limit / year.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	Not covered	Subject to <u>formulary</u> guidelines. Prosthetic arms and legs: 20% <u>coinsurance</u> , <u>deductible</u> does not apply.
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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](#).)**

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Children's glasses</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult and child)</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>• Routine eye care (Adult and child)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---|---|---|

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

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture (12 visit limit / year)</li> <li>• Bariatric surgery</li> <li>• Chiropractic care (30 visit limit / year)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (Adults: \$1,000 limit / ear / 12 months; Children: no limit)</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing (inpatient)</li> </ul> |
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**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 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	1-855-249-5005 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</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> .
Colorado Department of Insurance	303-894-7490 (instate, toll-free: 800-930-3745) or <a href="mailto:insurance@dora.state.co.us">insurance@dora.state.co.us</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 1-855-249-5005 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 (TTY: 711)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-249-5005 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-855-249-5005 (TTY: 711)

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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](#) \$900
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other \(blood work\) coinsurance](#) 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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$30
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,290</b>

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

- The [plan's](#) overall [deductible](#) \$900
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other \(blood work\) coinsurance](#) 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	\$900
Copayments	\$400
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,760</b>

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

- The [plan's](#) overall [deductible](#) \$900
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other \(x-ray\) coinsurance](#) 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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$0
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>