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, call 1-888-927-7526. 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 **https://www.healthcare.gov/sbc-glossary/** or call 1-800-877-1122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-network**: $0/individual or $0/family **Out-of-network**: Not covered (individual or family)	See the Common Medical Events chart on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	You will have to meet the deductible before the plan pays for any services.
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?	**In-network**: $1,500/individual or $3,000/family (medical, prescription and mental health combined) **Out-of-network**: Not covered/individual or Not covered/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?	Premiums, balance billing charges, copayments for certain services, 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 1-866-213-3062 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 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. Self referrals can be made to network specialists in optometry, psychiatry, chemical dependency, obstetrics and gynecology.

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	Not covered	None
	Specialist visit	$25 copay/visit	Not covered	Referral from personal physician required except for services noted on page 1.
	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$50 copay/visit	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 1-888-927-7526	Generic drugs	KP Pharmacy or Mail Order Pharmacy 30 days supply: $10 copay Community Network Pharmacy 30 days supply: $20 copay Mail Order Pharmacy 31 to 90 days supply: $20 copay*	Same as prior column. Only covered if related to out-of-area emergency/urgent care and can't be filled at network pharmacy.	Must be prescribed by network provider authorized to prescribe drugs or the following: 1) dentist, 2) non-network provider if patient is referred by a network physician, 3) non-network provider if drug is related to covered out-of-area urgent/emergency care. Up to 30 days supply through Community Network Pharmacy limited to first fill of prescription in Mid-Atlantic States and Georgia *31-100 days supply in California Prescription drug coupons may not apply to the out-of-pocket maximum.
	Preferred brand drugs	KP Pharmacy or Mail Order Pharmacy 30 days supply: $20 copay Community Network Pharmacy 30 days supply: $30 copay Mail Order Pharmacy 31 to 90 days supply: $40 copay*	Same as prior column. Only covered if related to out-of-area emergency/urgent care and can't be filled at network pharmacy.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 copay/visit	Not covered	None

	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	**Emergency room care**	$100 **copay**/visit	$100 **copay**/visit	Non-**network** emergency care covered if patient is temporarily out of area or using **network** facility isn't reasonable based on patient's condition/symptoms. Pre-authorization required for non-**network** post-stabilization care. Kaiser Permanente must be notified within 24 hours or as soon as reasonably possible following non-**network** emergency admission.
	Emergency medical transportation	$100 **copay**	$100 **copay**	Must be provided by ground or air licensed ambulance. No other type of transportation covered.
	Urgent care	$25 **copay**/visit	$25 **copay**/visit	Non-**network** urgent care covered if patient is temporarily out of area or accessing **network** facility isn't reasonable based on patient's condition/symptoms. Prior authorization required for non-**network** post-stabilization care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 **copay**/admission	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Individual: $25 **copay**/visit Group: $12 **copay**/visit	Not covered	Excludes psychological testing for ability, aptitude intelligence or interest. Includes 6 annual Employee Assistance Program (EAP) visits per issue at no charge.
	Inpatient services	$250 **copay**/admission	Not covered	None
If you are pregnant	Office visits	No charge for prenatal and post-partum visits	Not covered	After confirmation of pregnancy.
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	$250 **copay**/admission	Not covered	None

If you need help recovering or have other special health needs	**Home health care**	No charge	Not covered	Nurse visit limit: 2 hours/day; aide visit limit: 4 hours/day. Any time over limit is an additional visit. 100 visit maximum/calendar year
	Rehabilitation services	$25 **copay**/visit	Not covered	Therapy to treat the following isn't covered: There is no restorative potential; congenital learning/or neurological disability/disorder; communications training; educational training; vocational training/retraining including sports physical therapy; speech therapy that is not **medically necessary**.
	Habilitation services	$25 **copay**/visit	Not covered	None
	Skilled nursing care	No charge	Not covered	100 days maximum/calendar year for facilities only.
	Durable medical equipment	No charge	Not covered	Must be on Kaiser Permanente's DME, External Prosthetic and Orthotic **formulary** to be covered.
	Hospice services	No charge	Not covered	**Network provider** must diagnose terminal illness and determine life expectancy is 12 months or less.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	One **screening** with wellness exam. Also includes refraction exam.
	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.)

- Abortion (unless medically necessary)
- Contraceptives (unless medically necessary)
- Cosmetic Surgery Dental Care *(adult/child)*
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Routine Eye Care *(adult)*
- 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.)		
• Acupuncture • Bariatric Surgery	• Chiropractic Care (20 visit limit. Referral from personal physician may be required)	• Private Duty Nursing (requirements and restrictions apply to service and service provider)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact CPS at 1-888-927-7526 or ***info@ConcordiaPlans.org***. 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 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 CPS at 1-888-927-7526 or ***info@ConcordiaPlans.org*** . Additionally, a consumer assistance program can help you file your **appeal**. For information regarding your own state's consumer assistance program refer to http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 1-800-793-6922.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-793-6922.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-793-6922.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-793-6922.

——————————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	$0
Specialist copayment	$25
Hospital (facility) copayment	$250
Other copayment	$25

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$250
Other copayment	$25

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	$0
Copayments	$600
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	$0
Specialist copayment	$25
Hospital (facility) copayment	$250
Other copayment	$25

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

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