




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: \$2,000/individual or \$4,000 /family (medical, prescription and mental health combined) Out-of-network: Not covered (individual or family)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan has a non-embedded deductible. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes In-network preventive care services are not subject to a deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. 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 covered preventive services , at https://www.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 ?	In-network: \$3,000/individual or \$6,000 /family (medical, prescription and mental health combined) Out-of-network: Not covered	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	\$30 copay /visit	Not covered	None
	Specialist visit	\$30 copay /visit	Not covered	None
	Preventive care/Screening/immunization	No charge Deductible does not apply.	Not covered	If provided by network personal physician, pediatrician or family practice physician. 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)	\$10 copay /visit	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: \$10 up to 30-day supply \$20 up to 60-day supply \$30 up to 90-day supply (100 in CA) Mail Order Pharmacy: \$10 up to 30-day supply \$20 up to 90-day supply (100 in CA) Community Network Pharmacy: \$20 up to 30-day supply	Same as Network coverage. 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
	Preferred brand drugs	KP Pharmacy: \$20 up to 30-day supply \$40 up to 60-day supply \$60 up to 90-day supply (100 in CA) Mail Order Pharmacy: \$20 up to 30-day supply \$40 up to 90-day supply (100 in CA) Community Network Pharmacy:	Same as Network coverage. Only covered if related to out-of-area emergency/urgent care and can't be filled at network pharmacy.	Prescription drug coupons may not apply to the out-of-pocket maximum.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-network provider</u> (You will pay the most)	
		\$30 up to 30-day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> /visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	Non- <u>network</u> emergency care covered if patient is temporarily out of area or using <u>network</u> facility isn't reasonable based on patient's condition/symptoms. <u>Preauthorization</u> required for non- <u>network</u> post-stabilization care. Kaiser Permanente must be notified within 24 hours or as soon as reasonably possible following non- <u>network</u> emergency admission.
	<u>Emergency medical transportation</u>	\$100 <u>copay</u> /trip	\$100 <u>copay</u> /trip	Must be provided by ground or air licensed ambulance. No other type of transportation covered.
	<u>Urgent care</u>	\$30 <u>copay</u> /visit	\$30 <u>copay</u> /visit	Non- <u>network</u> urgent care covered if patient is temporarily out of area or accessing <u>network</u> facility isn't reasonable based on patient's condition/symptoms. <u>Preauthorization</u> required for non- <u>network</u> post-stabilization care.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /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: \$30 <u>copay</u> /visit Group: \$15 <u>copay</u> /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 <u>copay</u> /admission	Not covered	None
If you are pregnant	Office visits	No charge for prenatal and post-partum visits. <u>Deductible</u> does not apply.	Not covered	After confirmation of pregnancy

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-network provider</u> (You will pay the most)	
	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	<u>Home health care</u>	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.
	<u>Rehabilitation services</u>	Inpatient: \$250 copay /visit Outpatient: \$30 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 .
	<u>Habilitation services</u>	Inpatient: \$250 copay /visit Outpatient: \$30 copay /visit	Not covered	None
	<u>Skilled nursing care</u>	\$250 copay	Not covered	100 days maximum/calendar year for facilities only.
	<u>Durable medical equipment</u>	No charge	Not covered	Must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered.
	<u>Hospice services</u>	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 (*unless for medically necessary reconstructive surgery and related services*)
- Dental Care (*adult/child*)
- Experimental & Investigational Procedures
- Habilitation services (unless **medically necessary**)
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S Routine Eye Care (*adult*)
- Routine Foot Care (*unless for certain medical 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
- Bariatric Surgery (**preauthorization** required through Kaiser Permanente)
- 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, kwijigo 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	\$2,000
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$250
■ Other copayment	\$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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost sharing	
Deductibles	\$2,000
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,460

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$250
■ Other copayment	\$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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost sharing	
Deductibles	\$2,000
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,520

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$250
■ Other copayment	\$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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost sharing	
Deductibles	\$2,000
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

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