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 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?	$ 500/Individual or $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, preventive care, durable medical equipment	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	$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.	The Plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

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 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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not covered.	None.
	Specialist visit	$35 copay/visit	Not covered.	
	Preventive care/screening/ immunization	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 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)	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	20% coinsurance	
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	$50 copay/visit	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	No charge.	Not covered.	

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	$25 copay/day individual / $12 copay/day group	Not covered.	There is 20% coinsurance for partial hospitalization for which prior authorization is required.
	Inpatient services	20% coinsurance	Not covered.	Prior authorization is required.
	Colleague Group	30% coinsurance	30% coinsurance	The plan will reimburse 70% up to a maximum reimbursable fee of $40. The member is responsible for all costs above that amount.
If you are pregnant	Office visits	$25 copay/PCP / $35 copay specialist	Not covered.	Copay applies only to the visit to confirm pregnancy.
	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	Home health care	No charge.	Not covered.	Includes nurse visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year.
	Rehabilitation services	$25 copay/visit	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.
	Habilitation services	$25 copay/visit	Not covered.	
	Skilled nursing care	20% coinsurance	Not covered.	Limited to 60 days per plan year, combined with acute rehabilitation.
	Durable medical equipment	20% coinsurance	Not covered.	None.
	Hospice services	No charge.	Not covered.	None.
If your child needs dental or eye care	Children's eye exam	$35 copay/visit	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.	

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

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	$10 copay	$10 for up to a 30-day supply, $20 for up to a 90-day supply	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.
	Preferred brand drugs	$30 copay	$30 for up to a 30-day supply, $60 for up to a 90-day supply	
	Specialty drugs	$30 copay	$30 for up to a 30-day supply, $60 for up to a 90-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)
- 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[1]. 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.

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, kwiijigo holne' (800) 480-9967.

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

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

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	$12,739

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$90
Coinsurance	$2,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,651

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$970
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,898

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	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$205
Coinsurance	$172
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$877

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