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 call **1-800-216-2166.** To get a copy of the complete terms of coverage, contact MAPMG Benefits Depart. (MAPMG-Benefits@kp.org) or call 1-301-816-7192. 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100 per person up to $200 per family**. Any charges or portions of charges for services that are not covered services, as well as charges in excess of reasonable and customary charges may not be used to meet the deductible.	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 policy, the overall family deductible must meet before the plan begins to pay.
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?	**Not Applicable**	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	**Not Applicable**	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	**Not Applicable**	This plan does not use a provider network. You may receive covered services from any provider.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

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	Not covered	Not covered	
	Specialist visit	20% coinsurance	20% coinsurance	Authorized Evidence of Exclusion (also referred to as Denial of Service Letter) from KFHP is required. $1,000 annual limit for Chiropractic care.
	Preventive care/screening/ immunization	Not covered	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling **1-800-216-2166.**	Generic drugs	20% coinsurance	20% coinsurance	Only for those Prescription Drugs prescribed in connection with services not normally provided by Kaiser Foundation Health Plan. Medical foods and the use of FDA-approved prescription drugs outside FDA-approved indications are not covered.
	Preferred brand drugs	20% coinsurance	20% coinsurance	
	Non-preferred brand drugs	20% coinsurance	20% coinsurance	
	Specialty drugs	20% coinsurance	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	
	Physician/surgeon fees	Not covered	Not covered	
If you need immediate medical attention	Emergency room care	Not covered	Not covered	
	Emergency medical transportation	Not covered	Not covered	
	Urgent care	Not covered	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	
	Physician/surgeon fees	Not covered	Not covered	

*For more information about limitations and exceptions call **1-800-216-2166.**

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	20% coinsurance	Authorized Evidence of Exclusion from KFHP is required.
	Inpatient services	20% coinsurance	20% coinsurance	Authorized Evidence of Exclusion from KFHP is required.
If you are pregnant	Office visits	Not covered	Not covered	
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	Authorized Evidence of Exclusion from KFHP is required. Must be totally and permanently disabled for custodial care.
	Rehabilitation services	20% coinsurance	20% coinsurance	Authorized Evidence of Exclusion from KFHP is required. Vocational rehabilitation and charges for education, training or instruction are not covered.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	20% coinsurance/ noncustodial room and board and ill-patient physician visits; 50% coinsurance / custodial	20% coinsurance/ noncustodial room and board and ill-patient physician visits; 50% coinsurance / custodial	Authorized Evidence of Exclusion from KFHP is required. Services must be provided at a Skilled Nursing Facility. Must be totally and permanently disabled for custodial care.
	Durable medical equipment	20% coinsurance	20% coinsurance	Authorized Evidence of Exclusion from KFHP is required.
	Hospice services	Not covered	Not covered	Authorized Evidence of Exclusion from KFHP is required. Home care limited to 100 visits.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

*For more information about limitations and exceptions call **1-800-216-2166.**

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult)
- Hearing Aids
- 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 (must be medically necessary; maintenance not covered)
- Chiropractic care (must be medically necessary; $1,000 annual limit)
- Infertility treatment (Authorized Evidence of Exclusion from KFHP and itemized bill required; surrogate services not covered; $30,000 lifetime maximum; individual claimant must be infertile due to medical condition)
- Private duty nursing for hospice (only if certain conditions met)

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: Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa/healthreform. 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 on how 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: **1-510-271-5940**. You can also contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa/healthreform.

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? **No**
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.

*For more information about limitations and exceptions call **1-800-216-2166.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-216-2166**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-216-2166**.

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码**1-800-216-2166**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-216-2166**.

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

*For more information about limitations and exceptions call **1-800-216-2166.**

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	**$100**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other 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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,700**

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

The plan's overall deductible	**$100**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other 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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,600
The total Joe would pay is	**$5,600**

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

The plan's overall deductible	**$100**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other 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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

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