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 1-888-927-7526 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. This includes chiropractic copays.	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-Day Supply: $10 copay Community Network Pharmacy 30-Day Supply: $20 copay Mail Order Pharmacy 31 to 90-Day 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-day supply through Community Network Pharmacy limited to first fill of prescription in Mid-Atlantic States and Georgia *31 to 100 day supply in California
	Preferred brand drugs	KP Pharmacy or Mail Order Pharmacy 30-Day Supply: $20 copay Community Network Pharmacy 30-Day Supply: $30 copay Mail Order Pharmacy 31 to 90-Day 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

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 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 first post-partum visit	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

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 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 day maximum/calendar year
	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 *(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, 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.