




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 <a href="#">deductible</a> ?	<b>In-network:</b> \$0/individual or \$0/family <b>Out-of-network:</b> Not covered (individual or family)	See the Common Medical Events chart on page 2 for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In-network:</b> \$1,500/individual or \$3,000/family (medical, prescription and mental health combined) <b>Out-of-network:</b> Not covered/individual or Not covered/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, <a href="#">copayments</a> for certain services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes See <a href="http://www.kp.org">www.kp.org</a> or call 1-866-213-3062 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . Self <a href="#">referrals</a> can be made to <a href="#">network specialists</a> 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
		<a href="#">Network Provider</a> (You will pay the least)	<a href="#">Out-of-network provider</a> (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit	Not covered	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit	Not covered	<a href="#">Referral</a> from personal physician required except for services noted on page 1.
	<a href="#">Preventive care/Screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$50 <a href="#">copay</a> /visit	Not covered	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available by calling 1-888-927-7526	Generic drugs	KP Pharmacy or Mail Order Pharmacy 30-Day Supply: \$10 <a href="#">copay</a> Community <a href="#">Network</a> Pharmacy 30-Day Supply: \$20 <a href="#">copay</a> Mail Order Pharmacy 31 to 90-Day Supply: \$20 <a href="#">copay</a> *	Same as prior column. Only covered if related to out-of-area emergency/urgent care and can't be filled at <a href="#">network</a> pharmacy.	Must be prescribed by <a href="#">network provider</a> authorized to prescribe drugs or the following: 1) dentist, 2) non- <a href="#">network provider</a> if patient is referred by a <a href="#">network</a> physician, 3) non- <a href="#">network provider</a> if drug is related to covered out-of-area urgent/emergency care.
	Preferred brand drugs	KP Pharmacy or Mail Order Pharmacy 30-Day Supply: \$20 <a href="#">copay</a> Community <a href="#">Network</a> Pharmacy 30-Day Supply: \$30 <a href="#">copay</a> Mail Order Pharmacy 31 to 90-Day Supply: \$40 <a href="#">copay</a> *	Same as prior column. Only covered if related to out-of-area emergency/urgent care and can't be filled at <a href="#">network</a> pharmacy.	Up to 30-day supply through Community <a href="#">Network</a> Pharmacy limited to first fill of prescription in Mid-Atlantic States and Georgia  *31-100 day supply in California  Prescription drug coupons may not apply to the out-of-pocket maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$25 <a href="#">copay</a> /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	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit	\$100 <a href="#">copay</a> /visit	Non- <a href="#">network</a> emergency care covered if patient is temporarily out of area or using <a href="#">network</a> facility isn't reasonable based on patient's condition/symptoms. Pre-authorization required for non- <a href="#">network</a> post-stabilization care. Kaiser Permanente must be notified within 24 hours or as soon as reasonably possible following non- <a href="#">network</a> emergency admission.
	<a href="#">Emergency medical transportation</a>	\$100 <a href="#">copay</a>	\$100 <a href="#">copay</a>	Must be provided by ground or air licensed ambulance. No other type of transportation covered.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit	\$25 <a href="#">copay</a> /visit	Non- <a href="#">network</a> urgent care covered if patient is temporarily out of area or accessing <a href="#">network</a> facility isn't reasonable based on patient's condition/symptoms. Prior authorization required for non- <a href="#">network</a> post-stabilization care.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> /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 <a href="#">copay</a> /visit Group: \$12 <a href="#">copay</a> /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 <a href="#">copay</a> /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 <a href="#">copay</a> /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	<a href="#">Home health care</a>	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
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a> /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 <a href="#">medically necessary</a> .
	<a href="#">Habilitation services</a>	\$25 <a href="#">copay</a> /visit	Not covered	None
	<a href="#">Skilled nursing care</a>	No charge	Not covered	100 day maximum/calendar year for facilities only.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	Must be on Kaiser Permanente's DME, External Prosthetic and Orthotic <a href="#">formulary</a> to be covered.
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Network provider</a> 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 <a href="#">screening</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Abortion (unless <a href="#">medically necessary</a>)</li> <li>Contraceptives (unless <a href="#">medically necessary</a>)</li> <li>Cosmetic Surgery (unless for medically necessary reconstructive surgery and related services)</li> <li>Dental Care (adult/child)</li> </ul>	<ul style="list-style-type: none"> <li>Experimental &amp; Investigational Procedures</li> <li>Habilitation services (unless <a href="#">medically necessary</a>)</li> <li>Infertility Treatment</li> <li>Long-Term Care</li> </ul>	<ul style="list-style-type: none"> <li>Non-Emergency Care When Traveling Outside the U.S. Routine Eye Care (adult)</li> <li>Routine Foot Care (unless for certain medical conditions)</li> <li>Weight Loss Programs</li> </ul>

**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](mailto: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](http://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](mailto: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.

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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$360</b>

**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)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$620</b>

**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)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>

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