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, 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?	Network: **$1,000** Individual / **$2,000** 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, for example, network preventive care, emergency room care, urgent care, and certain telehealth services.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But 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 preventive services at 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?	Network: **$5,000** Individual / **$10,000** 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.	This **plan** will pay for 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**.

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

**See Page 5 for important information about telehealth services.

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 **Deductible** does not apply	Not covered.	None.
	Specialist visit	$45 copay/visit **Deductible** does not apply	Not covered.	None.
	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. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.
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 **Deductible** does not apply	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	$60 copay/visit **Deductible** does not apply	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			

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
**See Page 5 for important information about telehealth services.

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	Individual: $30 copay/ visit Group: $12 copay/visit **Deductible** does not apply	Not covered.	None.
	Inpatient services	20% coinsurance	Not covered.	Prior authorization is required.
If you are pregnant	Office visits	No charge.	Not covered.	None.
	Childbirth/delivery professional services	20% coinsurance	Not covered.	Well-newborn care is covered. Newborn must be enrolled in the **plan** within 30 days of birth.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Includes nurses visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	$30 PCP/ $45 specialist copay/visit **Deductible** does not apply	Not covered.	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	Habilitation services	$30 PCP/ $ 45 specialist copay/visit **Deductible** does not apply	Not covered.	
	Skilled nursing care	20% coinsurance	Not covered.	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	20% coinsurance **Deductible** does not apply	Not covered.	None.
	Hospice services	No charge.	Not covered.	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	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.

**See Page 5 for important information about telehealth services.

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	Up to a $10 copay	Up to a $10 copay for a 30-day supply; up to a $20 copay for a 90-day supply	**Deductible** does not apply. You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery (up to a 30-day supply for specialty drugs). California residents may receive up to a 100-day supply when using home delivery. No charge for contraceptives.
	Preferred brand drugs	Up to a $30 copay	Up to a $30 copay for a 30-day supply; up to a $60 copay for a 90-day supply	
	Non-preferred brand drugs	Up to a $70 copay	Up to a $70 copay for a 30-day supply; up to a $140 copay for a 90-day supply	
	Specialty drugs	Up to a $90 copay	Up to a $90 copay for a 30-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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (unless related to diabetes or certain other 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 (limit 20 visits per year)
- Bariatric surgery (if Medically Necessary)
- Chiropractic care (limit 20 visits per year)
- Hearing aids (limit $3,000 every three years)
- Infertility treatment ($50,000 lifetime maximum)
- Private duty nursing (only through home healthcare benefit)

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

**See Page 5 for important information about telehealth services.

Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for all telehealth services with a Kaiser Permanente provider.

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 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 Kaiser Permanente.

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 (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.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf (800) 480-9967 uff.

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.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
**See Page 5 for important information about telehealth services.

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	$1,000
Specialist *[cost sharing]*	$45
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,370**

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

The plan's overall deductible	$1,000
Specialist *[cost sharing]*	$45
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$800
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,860**

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

The plan's overall deductible	$1,000
Specialist *[cost sharing]*	$45
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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