福利和承保範圍摘要 (SBC) 文件將幫助您選擇健康計劃。SBC 向您展示您和計劃將如何共同承擔涵蓋的健康照護服務費用。
注意：有關此計劃費用（稱為保費）的資訊將另外提供。這僅是一份摘要。如欲了解有關承保範圍的更多資訊，或要獲得承保範圍的完整條款副本，請造訪 www.kp.org/plandocuments 或致電 1-800-788-0710 (TTY: 711)。如欲了解常見詞彙的一般定義，例如允許額、差額收費、共同保險、共付額、自付額、供應商、或其他劃線詞彙，請參見詞彙表。您可以在 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Chinese-Uniform-Glossary-05-2020-508.pdf 查看詞彙表，或致電 1-800-788-0710 (TTY: 711) 以索取副本。

重要問題	答案	為什麼這很重要：
整體自付額為多少？	參與供應商層級：個人 $350 / 家庭 $700。非參與供應商層級：個人 $1,000 / 家庭 $2,000	一般而言，在此計劃開始支付前，您需要向供應商支付自付額以下的所有費用。如果您還有其他家庭成員投保此計劃，在所有家庭成員支付的自付額費用總金額達到家庭整體自付額之前，每位家庭成員必須達到其自己的自付額。
在您達到您的自付額前，這些服務是否在承保範圍內？	是。預防性護理以及從第 2 頁開始之表格所示的服務。	即便您還沒達到自付額，此計劃亦涵蓋一些項目和服務。但可能需支付共付額或共同保險。例如：在沒有分攤成本且您達到您的自付額前，此計劃亦涵蓋特定預防性服務。請至 https://www.healthcare.gov/coverage/preventive-care-benefits/ 查看涵蓋的預防性服務清單。
特定服務是否還有其他自付額？	否	針對特定服務，您不需要達到自付額。
此計劃的最大自付額是多少？	參與供應商層級：個人 $7,800 / 家庭 $15,600。非參與供應商層級：個人 $15,600 / 家庭 $31,200	最大自付額為您可能在一年間為涵蓋服務支付的最大金額。如果您還有其他家庭成員投保此計劃，在達到家庭整體最大自付額之前，其他家庭成員必須達到其自己的最大自付額。
最大自付額不包含什麼？	保費、未取得預先證明的罰款、差額收費的費用以及此計劃不涵蓋的健康照護服務，詳如第 2 頁開始之表格所示。	即便您已支付此類費用，相關費用亦不計入最大自付額。
如果使用網絡供應商，您支付的金額是否會更少？	是。請參見 www.kp.org/kpic/ppo 或致電 1-800-788-0710 (TTY: 711) 以索取網絡供應商清單。	此計劃使用供應商網絡。如果您使用計劃網絡中的供應商，您將需要支付較少費用。如果您使用網絡外的供應商，您將需要支付較多費用。您亦可能收到來自供應商的帳單，其中為供應商收費及您的計劃支付的費用差額（差額收費）。請注意，您的網絡供應商可能使用網絡外供應商以提供一些服務（例如：實驗室工序）。請在獲取服務前與您的供應商確認。
您是否需要轉診至專科醫生？	否。	您可以在沒有轉介的前提下至您選擇的專科醫生處就診。

此表格顯示的所有**共付額**和**共同保險**費用僅適用於您已達到您的**自付額**的情況（如果**自付額**適用的話）。

常見醫療事件	您可能需要的服務	您需要支付的費用 參與供應商層級 （您將需要支付較少費用）	您需要支付的費用 非參與供應商層級 （您將需要支付較多費用）	限制、例外和其他重要資訊
如果您造訪健康照護供應商的辦公室或診所	初級保健就診以治療受傷或疾病	每次就診 $25，自付額不適用	40% 共同保險	無
	至專科醫生處就診	每次就診 $50，自付額不適用	40% 共同保險	無。
	預防性照護/篩查/疫苗接種	不收費，自付額不適用	40% 共同保險，自付額不適用	由非參與供應商提供的例行身體檢查不屬於承保範圍。您可能需要為非預防性服務付費。請向您的供應商洽詢您所需的服務是否屬於預防性服務。然後查看您的計劃將會支付哪些費用。
如果您進行檢測	診斷檢定（X 光、血液檢測）	X 光：每次檢定 $65，自付額不適用。化驗：每次檢定 $25，自付額不適用	40% 共同保險	無。
	造影（CT/PET 掃描、MRI）	20% 共同保險，自付額不適用	40% 共同保險	需要預先證明。若未取得預先證明，可能最多會罰款 $500。
如果您需要藥物治療疾病或情況 如欲了解更多有關**處方類藥物的承保範圍**， 請造訪 www.kp.org/kpic/ppo	學名藥	MedImpact：每份處方 $15（零售），每份處方 $30（郵購），自付額不適用	不承保	零售最多 30 天藥量或郵購（Walgreens 的寄送到府）最多 100 天藥量。需遵守處方集準則。避孕藥不收費。
	優先原廠藥	MedImpact：每份處方 $50（零售），每份處方 $100（郵購），自付額不適用	不承保	零售最多 30 天藥量或郵購（Walgreens 的寄送到府）最多 100 天藥量。需遵守處方集準則。避孕藥不收費。
	非優先原廠藥	MedImpact：每份處方 $50（零售），每份處方 $100（郵購），自付額不適用	不承保	零售最多 30 天藥量或郵購（Walgreens 的寄送到府）最多 100 天藥量。需遵守處方集準則。避孕藥不收費。
	專科藥物	MedImpact：20% 共同保險，每份處方最多 $250，自付額不適用	不承保	零售最多 30 天藥量。需遵守處方集準則。

常見醫療事件	您可能需要的服務	您需要支付的費用 參與供應商層級 （您將需要支付較少費用）	您需要支付的費用 非參與供應商層級 （您將需要支付較多費用）	限制、例外和其他重要資訊
如果您進行門診手術	設施費（例如：非住院手術中心）	20% 共同保險，自付額不適用	40% 共同保險	需要預先證明。若未取得預先證明，可能最多會罰款 $500。
	醫師/外科醫生費用	20% 共同保險，自付額不適用	40% 共同保險	需要預先證明。若未取得預先證明，可能最多會罰款 $500。
如果您需要立即就醫	急診室照護	20% 共同保險	20% 共同保險	若以住院患者的身分入院，則免共同保險。
	緊急醫療交通	20% 共同保險	20% 共同保險	無。
	緊急照護	每次就診 $25，自付額不適用	40% 共同保險	無。
如果您需要住院	設施費（例如：醫院病房）	20% 共同保險	40% 共同保險	需要預先證明（急診或全乳房切除手術／淋巴結外科手術後的住院天數除外）。若未取得預先證明，可能最多會罰款 $500。
	醫師/外科醫生費用	20% 共同保險	40% 共同保險	需要預先證明（急診或全乳房切除手術／淋巴結外科手術後的住院天數除外）。若未取得預先證明，可能最多會罰款 $500。
如果您需要心理健康、行為健康或藥物濫用服務	門診服務	每次個人就診 $25，自付額不適用。其他門診服務不收費，自付額不適用。	40% 共同保險	參與供應商：每次團體就診 $12，自付額不適用
	住院服務	20% 共同保險	40% 共同保險	需要預先證明（不適用於緊急住院和急診服務）。若未取得預先證明，可能最多會罰款 $500。
如果您懷孕	辦公室就診	不收費，自付額不適用	40% 共同保險，自付額不適用	根據服務類型，共付額、共同保險或自付額可能適用。妊娠照護可能包括 SBC 其他地方所述的檢測和服務（即超音波）。
	分娩專業服務	20% 共同保險	40% 共同保險	無。
	分娩設施服務	20% 共同保險	40% 共同保險	需要預先證明（若自然生產／剖腹生產後的妊娠住院超過48/96小時）。若未取得預先證明，可能最多會罰款 $500。

常見醫療事件	您可能需要的服務	您需要支付的費用 參與供應商層級 （您將需要支付較少費用）	您需要支付的費用 非參與供應商層級 （您將需要支付較多費用）	限制、例外和其他重要資訊
如果您需要康復協助或有其他特殊健康需求	居家照護	20% 共同保險，自付額不適用	40% 共同保險	每年合計最多 100 次探訪。（限制不適用於物理治療、職業治療及言語治療就診，也不適用於精神健康及藥物濫用障礙治療）。需要預先證明。若未取得預先證明，可能最多會罰款 $500。
	復健服務	門診：每次就診 $25，自付額不適用 住院：20% 共同保險	40% 共同保險	需要預先證明。若未取得預先證明，可能最多會罰款 $500。
	適應服務	門診：每次就診 $25，自付額不適用 住院：20% 共同保險	40% 共同保險	需要預先證明。若未取得預先證明，可能最多會罰款 $500。
	專業護理	20% 共同保險	40% 共同保險	每個福利期最多 100 天。需要預先證明。（日數上限不適用於醫療上必要的精神健康及藥物濫用障礙治療）。若未取得預先證明，可能最多會罰款 $500。
	耐用醫療器材	20% 共同保險，自付額不適用	40% 共同保險	某些器材每年最多限 $2,000。需要預先證明。若未取得預先證明，可能最多會罰款 $500。
	臨終關懷服務	不收費，自付額不適用	40% 共同保險	無
如果您的子女需要牙科或眼科照護	兒童眼科檢查	不收費，自付額不適用	不收費	每年限 1 次檢查
	兒童眼鏡	不收費，自付額不適用	20% 共同保險	每年限 1 副眼鏡，鏡框和鏡片樣式有限。
	兒童牙科檢查	不收費，自付額不適用	不收費，自付額不適用	每年限 2 次檢查

不包含的服務和其他承保服務：

您的計劃一般不涵蓋的服務（查看您的保單或計劃文件以了解更多資訊以及任何其他不包含的服務列單。）

- 脊柱神經照護
- 美容手術
- 牙科照護（成人）
- 助聽器
- 長期照護
- 在美國境外旅行時的非急診照護
- 私人護理
- 例行足部保健
- 減重計劃

其他包含的服務（此類服務可能存有限制。這不是完整的列單。請查看您的計劃文件。）

- 針灸
- 減肥手術
- 不孕症治療（每年限 $1,000）
- 例行眼科照護（成人）

您的續保權利：如果您想在保險結束後繼續獲得承保，有一些機構可以提供協助。此類機構的聯繫資訊如下表所示。其他承保選項亦可能適用於您，其中包括透過健康保險商城購買個人保險。如欲了解更多有關商城的資訊，請造訪 www.HealthCare.gov 或致電 1-800-318-2596。

您的申訴和上訴權利：如果您對您的計劃拒絕您的索償提出投訴，一些機構可以為您提供協助。此類投訴被稱為申訴或上訴。如欲了解有關您權利的更多資訊，請查看您就該醫療索償可取得的福利說明。您的計劃文件亦將提供有關如何出於任何理由就您計劃提交索償、上訴或申訴的完整資訊。如欲了解有關您的權利、此通知或幫助的更多資訊，請聯繫下表所列的機構。

如欲了解您的續保權利以及申訴和上訴權利，聯絡資訊如下：

Kaiser Permanente 會員服務部	1-800-788-0710 (TTY: 711) 或 www.kp.org/memberservices
勞工部員工福利安全管理局	1-866-444-EBSA (3272) 或 www.dol.gov/ebsa/healthreform
美國健康與民眾服務部消費者資訊與保險監管中心	1-877-267-2323 分機 61565 或 www.cciio.cms.gov
加州保險局	1-800-927-HELP (4357) 或 www.insurance.ca.gov

此計劃是否提供最低程度承保？是

最低程度承保一般包括可透過商城或其他獨立市場保單取得的計劃、健康保險、Medicare、Medicaid、CHIP、TRICARE、和其他特定保險。如果您符合特定類別最低程度承保的資格，您可能不符合保費稅額抵免優惠資格。

此計劃是否符合最低值標準？是

如果您的計劃不符合最低值標準，您可能符合保費稅額抵免優惠資格，可透過商城幫助您支付計劃費用。

語言服務：

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0710 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-788-0710 (TTY: 711).

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-788-0710 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-788-0710 (TTY: 711)

如欲查看此計劃涵蓋範例醫療情況費用的示例，請查看下一節。

PPO 計劃是由 Kaiser Foundation Health Plan, Inc. (KFHP) 的子公司 Kaiser Permanente Insurance Company (KPIC) 核保。

關於此類承保示例：

這不是費用預估。顯示的治療僅為此計劃涵蓋醫療照護的示例。您的確切費用取決於您獲取的確切照護、您的供應商收取的費用和其他很多因素，可能有所不同。專注於計劃下成本分攤金額（自付額、共付額和共同保險）和不包含的服務。利用此資訊來比較您在不同健康計劃中可能需要支付的費用部分。請注意，此類承保範圍示例僅基於自我承保範圍。

Peg 懷孕了
（9 個月的網絡內產前檢查和醫院分娩）

- 計劃的整體自付額 **$350**
- 專科醫生共付額 **$50**
- 醫院（設施）共同保險 **20%**
- 其他（血液檢測）共付額 **$25**

此事件示例包含下列服務：
專科醫生辦公室就診（*產前照護*）
分娩專業服務
分娩設施服務
診斷檢定（*超音波和血液檢測*）
專科醫生看診（*麻醉*）

總示例費用	**$12,700**
在此示例，Peg 將支付：	
成本分攤	
自付額	$350
共付額	$200
共同保險	$1600
不承保的項目	
限制或例外	$50
Peg 將支付的總金額為	**$2200**

管理 Joe 的 2 型糖尿病
（一年的病情可控例行網絡內護理）

- 計劃的整體自付額 **$350**
- 專科醫生共付額 **$50**
- 醫院（設施）共同保險 **20%**
- 其他（血液檢測）共付額 **$25**

此事件示例包含下列服務：
初級保健醫師辦公室就診（*包括疾病教育*）
診斷檢定（*血液檢測*）
處方藥
耐用醫療器材（*血糖測量儀*）

總示例費用	**$5,600**
在此示例，Joe 將支付：	
成本分攤	
自付額	$0
共付額	$1100
共同保險	$100
不承保的項目	
限制或例外	$0
Joe 將支付的總金額為	**$1200**

Mia 的簡單骨折
（網絡內急診室就診和後續護理）

- 計劃的整體自付額 **$350**
- 專科醫生共付額 **$50**
- 醫院（設施）共同保險 **20%**
- 其他（*X 光*）共付額 **$65**

此事件示例包含下列服務：
急診室照護（*包括醫療用品*）
診斷檢定（*X 光*）
耐用醫療器材（*拐杖*）
復健服務（*物理治療*）

總示例費用	**$2,800**
在此示例，Mia 將支付：	
成本分攤	
自付額	$350
共付額	$600
共同保險	$100
不承保的項目	
限制或例外	$0
Mia 將支付的總金額為	**$1050**

計劃將負責支付此類示例中所涵蓋服務所產生的其他費用。

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Non-English Summary of Benefits and Coverage Notice

The English version of the Summary of Benefits and Coverage (SBC) is the official version. The foreign language version is for informational purposes only. You can request an English version of this SBC from your employer or by calling **1-800-788-0710** or **1-800-777-1370 (TTY).**

Aviso sobre el Resumen de Beneficios y Cobertura en un idioma distinto al inglés

La versión oficial del *Resumen de Beneficios y Cobertura* (SBC) es la que está en inglés. La versión en otro idioma es solamente para fines informativos. Puede solicitar a su empleador la versión en inglés de este SBC o llamar al 1-800-788-0710 o al 1-800-777-1370 (línea TTY).

非英文版福利和承保範圍摘要公告

英文版*福利和承保範圍摘要*(SBC)為正式版本。外文版本僅供參考使用。您可向僱主索取一份英文版SBC，或致電**1-800-788-0710**或**1-800-777-1370 (TTY)**索取。

Nondiscrimination Notice

Kaiser Permanente Insurance Company (KPIC) does not discriminate based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). We can provide no cost aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats; large print, audio, and accessible electronic formats. We also provide no cost language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. To request these services, please call **1-800-464-4000** (TTY users call **711**).

If you believe that KPIC failed to provide these services or there is a concern of discrimination based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability you can file a complaint by phone or mail with the KPIC Civil Rights Coordinator. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you.

KPIC Civil Rights Coordinator
Grievance 1557
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-251-7052

You may also contact the California Department of Insurance regarding your complaint.

By Phone:
California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

By Mail:
California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

Electronically:
www.insurance.ca.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. You can file the complaint electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

KAISER PERMANENTE®

Kaiser Permanente Insurance Company
Notice of Language Assistance

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-464-4000. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

Servicios en otros idiomas sin ningún costo. Puede conseguir un intérprete. Puede conseguir que le lean los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-464-4000. Para obtener más ayuda, llame al Departamento de Seguro de CA al 1-800-927-4357. Los usuarios de la línea TTY deben llamar al 711. Spanish

免費語言服務。您可使用口譯員。您可請人將文件唸給您聽，且您可請我們將您語言版本的部分文件寄給您。如需協助，請致電列於會員卡上的電話號碼或致電 1-800-464-4000 與我們聯絡。如需進一步協助，請致電 1-800-927-4357 與加州保險局聯絡。聽障及語障電話專線使用者請致電 711。Chinese

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No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-464-4000. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

Doo bik'é azláágoo Saad Bee Áká Aná'álwo'. Ata' halne'í ná shóidoot'eeł. Nizaad bee naaltsoos nich'į' yídóoltah Shíká i'doolwoł nínízingo éí béésh bee hodíílnih, naaltsoos bee nééhózinígíí bik'ehgo hane'í bikáá' éí doodago kojį' hodíílnih 1-800-464-4000. Náánáłahgo ałdó' shíká i'doolwoł nínízingo kojį' hodíílnih CA Dept. of Insurance bik'ehgo hane'í éí 1-800-927-4357. TTY chodayooł'ígíí éí díí 711. Navajo

Dịch vụ về ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và được người đọc giấy tờ, tài liệu bằng ngôn ngữ quý vị dùng cho quý vị nghe. Để được giúp đỡ, xin gọi chúng tôi theo số điệnthoại ghi trên thẻ ID hội viên hoặc số 1-800-464-4000. Để được giúp đỡ thêm, vui lòng gọi Bộ Bảo hiểm CA theo số 1-800-927-4357. Người sử dụng TTY gọi số 711. Vietnamese

무료 언어 서비스. 한국어 통역 서비스 및 한국어로 서류를 낭독해 드리는 서비스를 제공하고 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와 있는 전화번호 또는 1-800-464-4000 번으로 문의하십시오. 보다 자세한 사항은 캘리포니아 주 보험국, 전화번호 1-800-927-4357 번으로 문의하십시오. TTY 사용자 번호 711. Korean

Mga Libreng Serbisyo kaugnay sa Wika. Maaari kayong kumuha ng tagasalin-wika at hingin na basahin sa inyo ang mga dokumento sa sarili ninyong wika. Para humingi ng tulong, tawagan kami sa numerong nakasulat sa inyong ID card o sa 1-800-464-4000. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Dapat tumawag ang mga gumagamit ng TTY sa 711. Tagalog

Անվճար լեզվական ծառայություններ: Դուք կարող եք օգտվել բանավոր թարգմանչի ծառայություններից և խնդրել, որ փաստաթղթերը Ձեր լեզվով կարդան Ձեզ համար:Օգնության համար զանգահարեք մեզ՝ Ձեր ID քարտի վրա նշված կամ 1-800-464-4000 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայիապահովագրության դեպարտամենտ՝ 1-800-927-4357 հեռախոսահամարով: TTY -ից օգտվողները պետք է զանգահարեն 711: Armenian

Бесплатные услуги языкового перевода. Вы можете воспользоваться услугами переводчика, при этом документы могут быть зачитаны Вам на Вашем языке. Чтобы получить помощь, позвоните нам по телефону, указанному в Вашей идентификационной карточке участника, или 1-800-464-4000. За дополнительной помощью обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357. Пользователи TTY, звоните по номеру 711. Russian

無料の言語サービス。通訳に依頼して、日本語で書類を読んでもらうことができます。通訳サービスが必要な際は、ID カードに記載の番号、または 1-800-464-4000 にお電話ください。さらにヘルプが必要な場合は、カリフォルニア州保険庁（1-800-927-4357）にお電話ください。TTY ユーザーの方は、711 にお電話ください。Japanese

خدمات زبان به صورت رایگان. می توانید از خدمات مترجم شفاهی بهره مند شوید و ترتیب خواندن متن ها برای شما به زبان خودتان را بدهید. برای دریافت کمک و راهنمایی، با ما به شماره ای که روی کارت شناسایی شما قید شده یا 1-800-464-4000تماس بگیرید. برای دریافت کمک و راهنمایی بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. کاربران TTY با شماره 711 تماس حاصل نمایند. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-464-4000 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ, ਕੈਲੀਫ਼ੋਰਨੀਆਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। TTY ਦੇ ਉਪਯੋਗਕਰਤਾ 711 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែបាន និងឲ្យគេអានឯកសារជូនអ្នក ជាភាសាខ្មែរ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើងតាមលេខដែលមាននៅលើប័ណ្ណ ID របស់អ្នក ឬ 1-800-464-4000។ សំរាប់ជំនួយថែមទៀត ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ អ្នកប្រើ TTY ហៅលេខ 711។ Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-464-4000. للحصول على مزيد من المعلومات اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. لمستخدمي خدمة الهاتف النصي يرجى الاتصال على 711.Arabic

Cov Kev Pab Txhais Lus Tsis Raug Nqi Dab Tsi Koj muaj tau ib tug neeg txhais lus thiabhais tau kom nyeem cov ntaub ntawv ua koj hom lus rau koj. Xav tau kev pab, hu rau peb ntawm tus xov toojteev muaj nyob rau ntawm koj daim yuaj ID los yog 1-800-464-4000. Xav tau kev pab ntxiv hu rau CA Tuam Tsev Tswj Kev Pov Hwm ntawm 1-800-927-4357. Cov neeg siv TTY hu rau 711. Hmong

मुफ्त भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं और आपको दस्तावेज़ आपकी भाषा में पढ़ कर सुनाए जा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिये नम्बर या 1-800-464-4000 पर हमें फोन करें। अधिक सहायता के लिए कैलीफ़ोर्निया डिपार्टमेंट ऑफ इंशोरेंस को 1-800-927-4357 पर फोन करें। TTY प्रयोक्ता 711 पर फोन करें। Hindi

บริการด้านภาษาที่ไม่คิดค่าบริการ คุณสามารถขอรับบริการล่ามแปลภาษาและขอให้อ่านเอกสารให้คุณฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อหาเราตามหมายเลขที่ระบุอยู่บนบัตร ID ของคุณหรือหมายเลข 1-800-464-4000 หากต้องการความช่วยเหลือในเรื่องอื่นๆ เพิ่มเติม โปรดโทรติดต่อฝ่ายประกันโรคมะเร็งที่หมายเลข 1-800-927-4357 ผู้ใช้ TTY โปรดโทรไปที่หมายเลข 711. Thai

KAISER PERMANENTE®
Kaiser Permanente Insurance Company : **Gold 80 PPO 350/25 + Child Dental**

Coverage for: Individual / Family | Plan Type: PPO

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 www.kp.org/plandocuments or call 1-800-788-0710 (TTY: 711). 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.healthcare.gov/sbc-glossary or call 1-800-788-0710 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating Provider Tier: $350 Individual / $700 Family. Non-Participating Provider Tier: $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. Preventive care and services indicated in chart starting on page 2.	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 covered preventive services at https://www.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?	Participating Provider Tier: $7,800 Individual / $15,600 Family. Non-Participating Provider Tier: $15,600 Individual / $31,200 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, precertification penalties, balance billing charges, and health care services this plan doesn't cover, indicated in chart starting on page 2.	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/kpic/ppo or call 1-800-788-0710 (TTY: 711) 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?	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
		Participating Provider Tier (You will pay the least)	Non-Participating Provider Tier (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 / visit, deductible does not apply	40% coinsurance	None
	Specialist visit	$50 / visit, deductible does not apply	40% coinsurance	None.
	Preventive care/screening/ Immunization	No charge, deductible does not apply	40% coinsurance, deductible does not apply	Routine physical exams are not covered for Non-Participating Provider. 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)	X-ray: $65 / test, deductible does not apply. Lab tests: $25 / test, deductible does not apply	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance, deductible does not apply	40% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/kpic/ppo	Generic drugs	MedImpact: $15 / prescription (retail), $30 / prescription (mail order), deductible does not apply	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines. No charge for contraceptives.
	Preferred brand drugs	MedImpact: $50 / prescription (retail), $100 / prescription (mail order), deductible does not apply	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines. No charge for contraceptives.
	Non-preferred brand drugs	MedImpact: $50 / prescription (retail), $100 / prescription (mail order), deductible does not apply	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines. No charge for contraceptives.
	Specialty drugs	MedImpact: 20% coinsurance up to $250 / prescription, deductible does not apply	Not covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance, deductible does not apply	40% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider Tier (You will pay the least)	Non-Participating Provider Tier (You will pay the most)	
	Physician/surgeon fees	20% coinsurance, deductible does not apply	40% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Coinsurance waived if admitted to hospital as inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	$25 / visit, deductible does not apply	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification required (except for emergencies, or length of stay following mastectomy/lymph node surgeries). Failure to precertify may result in a penalty of up to $500.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification required (except for emergencies, or length of stay following mastectomy/lymph node surgeries). Failure to precertify may result in a penalty of up to $500.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / individual visit, deductible does not apply. No charge for other outpatient services, deductible does not apply.	40% coinsurance	Participating Provider: $12 / group visit, deductible does not apply
	Inpatient services	20% coinsurance	40% coinsurance	Precertification required (does not apply to emergency admissions and services). Failure to precertify may result in a penalty of up to $500.
If you are pregnant	Office visits	No charge, deductible does not apply	40% coinsurance, deductible does not apply	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Precertification required (for maternity admission stays exceeding 48/96 hours for vaginal/caesarean deliveries). Failure to precertify may result in a penalty of up to $500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider Tier (You will pay the least)	Non-Participating Provider Tier (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance, deductible does not apply	40% coinsurance	Up to 100 visits combined / year. (Limit does not apply to physical, occupational, and speech therapy visits or to Treatment of Mental Health and Substance Use Disorders). Precertification required. Failure to precertify may result in a penalty of up to $500.
	Rehabilitation services	Outpatient: $25 / visit, deductible does not apply Inpatient: 20% coinsurance	40% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500.
	Habilitation services	Outpatient: $25 / visit, deductible does not apply Inpatient: 20% coinsurance	40% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500.
	Skilled nursing care	20% coinsurance	40% coinsurance	Up to 100 days / benefit period. Precertification required. (The day maximum does not apply to medically necessary treatment of Mental Health and Substance Use Disorders). Failure to precertify may result in a penalty of up to $500.
	Durable medical equipment	20% coinsurance, deductible does not apply	40% coinsurance	Up to $2,000 limit / year for certain items. Precertification required. Failure to precertify may result in a penalty of up to $500.
	Hospice services	No charge, deductible does not apply	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	No charge	Limited to 1 exam / year
	Children's glasses	No charge, deductible does not apply	20% coinsurance	Limited to 1 pair of glasses/year from select frames and lenses.
	Children's dental check-up	No charge, deductible does not apply	No charge, deductible does not apply	Limited to 2 check-ups / year

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.)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- 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 • Bariatric surgery	• Infertility treatment ($1,000 limit / year)	• Routine eye care (Adult)

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 shown in the chart below. 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-788-0710 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov

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 1-800-788-0710 (TTY: 711)

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-788-0710 (TTY: 711).

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-788-0710 (TTY: 711)

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-788-0710 (TTY: 711)

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

The PPO Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP)

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	**$350**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other (blood work) 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	$350
Copayments	$200
Coinsurance	$1600
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$2200**

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

The plan's overall deductible	**$350**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other (blood work) 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	$1100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1200**

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

The plan's overall deductible	**$350**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other (*x-ray*) copayment	**$65**

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	$350
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1050**

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