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-05-20-20508.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 $2,500 / 家庭 $5,000。非參與供應商層級：個人 $5,000 / 家庭 $10,000	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。預防性照護以及從第 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？	是。原廠及專科處方藥個人 $350/家庭 $700。沒有其他特定自付額。	在此計劃開始支付此類服務前，您必須支付所有此類服務費用的特定自付額。
此計劃的最大自付額是多少？	參與供應商層級：個人 $9,200 / 家庭 $18,400。非參與供應商層級：個人 $18,400 / 家庭 $36,800	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？	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。

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重要問題	答案	為什麼這很重要：
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		限制、例外和其他重要資訊
		參與供應商層級（您將需要支付較少費用）	非參與供應商層級（您將需要支付較多費用）	
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 $60，自付額不適用	40% 共同保險	無。
	至專科醫生處就診	每次就診 $90，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	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 $90，自付額不適用。 化驗：每次檢定 $55，自付額不適用。	40% 共同保險	無。
	造影（CT/PET 掃描、MRI）	每項診療程序 $300	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。

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常見醫療事件	您可能需要的服務	您需要支付的費用		限制、例外和其他重要資訊
		參與供應商層級（您將需要支付較少費用）	非參與供應商層級（您將需要支付較多費用）	
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：零售每份處方 $20；郵購每份處方 $40，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：達到藥物自付額後，每份處方 $90（零售），每份處方 $180（郵購）	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。
	非優先原廠藥	MedImpact：達到藥物自付額後，每份處方 $90（零售），每份處方 $180（郵購）	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。
	專科藥物	MedImpact：達到藥物自付額後，每份處方 30% 共同保險，最多 $250	不承保	零售最多 30 天藥量。需遵守處方集準則。
如果您進行門診手術	設施費（例如：非住院手術中心）	40% 共同保險	50% 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	40% 共同保險	50% 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	40% 共同保險	40% 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	40% 共同保險	40% 共同保險	無。
	緊急照護	每次就診 $60，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）	40% 共同保險	50% 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	40% 共同保險	50% 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。

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常見醫療事件	您可能需要的服務	您需要支付的費用		限制、例外和其他重要資訊
		參與供應商層級（您將需要支付較少費用）	非參與供應商層級（您將需要支付較多費用）	
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 $60，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 $30，自付額不適用
	住院服務	40% 共同保險	50% 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	40% 共同保險	50% 共同保險	無。
	分娩設施服務	40% 共同保險	50% 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。
如果您需要康復協助或有其他特殊健康需求	居家照護	每次就診 $45，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 $60，自付額不適用 住院：40% 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 $60，自付額不適用 住院：40% 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	40% 共同保險	50% 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	40% 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

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常見醫療事件	您可能需要的服務	您需要支付的費用		限制、例外和其他重要資訊
		參與供應商層級（您將需要支付較少費用）	非參與供應商層級（您將需要支付較多費用）	
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
- 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。

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語言服務：

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

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼1-800-788-0710 (TTY: 711)

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

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-278-3296 (TTY: 711) uff

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-278-3296 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-278-3296 (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。

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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 **$2,500**
- 專科醫生共付額 **$90**
- 醫院（設施）共同保險 **40%**
- 其他（血液檢測）共付額 **$55**

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	$2,500
共付額	$400
共同保險	$2,400
不承保的項目	
限制或例外	$50
Peg 將支付的總金額為	**$5,350**

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 **$2,500**
- 專科醫生共付額 **$90**
- 醫院（設施）共同保險 **40%**
- 其他（血液檢測）共付額 **$55**

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	$1,400
共同保險	$200
不承保的項目	
限制或例外	$0
Joe 將支付的總金額為	**$1,600**

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 **$2,500**
- 專科醫生共付額 **$90**
- 醫院（設施）共同保險 **40%**
- 其他（X 光）共付額 **$90**

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	$1,900
共付額	$500
共同保險	$0
不承保的項目	
限制或例外	$0
Mia 將支付的總金額為	**$2,400**

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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。

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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 ingles

La version oficial del *Resumen de Beneficios y Coberlura* (SBC) es la que esta en ingles. La version en otro idioma es solamente para fines informativos. Puede solicitar a su empleador la version en ingles de este SBC o llamar al 1-800-788-0710 o al 1-800-777-1370 (linea TTY).

Thông báo về phiên bản tài liệu Tóm Lược Quyền lợi và Bảo Hiểm bằng ngôn ngữ không phải tiếng Anh

Phiên bản tiếng Anh của tài liệu Tóm Lược Quyền lợi và Bảo Hiểm (SBC) là phiên bản chính thức. Phiên bản bằng ngôn ngữ khác chỉ nhằm mục đích tham khảo. Quý vị có thể yêu cầu nhận phiên bản tiếng Anh của SBC này từ chủ lao động của mình hoặc bằng cách gọi đến số 1-800-788-0710 (TTY: 711).

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。

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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 **1-800-788-0710** (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
P.O. Box 1809
Pleasanton, CA 94566
Phone: 1-800-788-0710

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

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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
Phone:1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html.

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Notice of Language Assistance

No Cost Language Services. You can get an interpreter and get documents read to you in your language. You may also request for materials to be translated into your language or alternative formats sent to you. For help, call us at the number listed on your ID card or 1-800-788-0710. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

Servicios de idioma sin costo. Puede obtener servicios de un intérprete y que le lea documentos en su idioma. También puede solicitar que traduzcan materiales a su idioma o que se le envíen en formatos alternativos. Si necesita ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-788-0710. Para obtener más información, llame al Departamento de Seguros de California al 1-800-927-4357. Los usuarios de TTY deben llamar al 711. Spanish

免費語言服務。您可使用口譯員並請人使用您的語言將文件唸給您聽。您也可以要求將資料翻譯成您的語言或以替代格式寄給您。如需幫助，請致電您會員證上所列的電話號碼或致電1-800-788-0710與我們聯絡。如需進一步幫助， 請致電1-800-927-4357與加州保險部聯絡。 TTY使用者請致電711。Chinese

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Bizaad bee áko t’áá íiyisí bá oolzinígíí. Díí bizaad bee naaltsoos nihá ályaaígíí t’áá íiyisí yíníłta’go bee hane’ doo naaltsoos nihá níłtsą. Díí naaltsoos nihá bąąh yáhoot’éél doo tł’oh yáti’ígíí éí nihá bąąh yáhoot’éélígíí t’áá íiyisí bee ná’álkidgo nihá dah naashá. Ákót’éego baa ahéél ná’ídlwo’, doo bik’ehgo naaltsoos bee naaznilígíí bikáá’ dah naashá ID béésh bee hane’gi t’áá ájít’éego bee hodíílnih doo 1-800-788-0710 áltsé. Díkwíí hóló holne’go, California Béésh Bee Hane’ Áłchíní Bá Hooghan bee 1-800-927-4357 bibeeso biká anilyeed. TTY yáhoot’éél nihá shikaad 711. Navajo

Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên và người đọc thông tin giấy tờ, tài liệu bằng ngôn ngữ quý vị dùng cho quý vị nghe. Quý vị cũng có thể yêu cầu dịch tài liệu sang ngôn ngữ của quý vị hoặc gửi đến quý vị các định dạng thay thế. Để được giúp đỡ, hãy gọi chúng tôi theo số điện thoại ghi trên thẻ Nhận Dạng (thẻ ID) của quý vị hoặc số 1-800-788-0710. Để được giúp đỡ thêm, vui lòng gọi Sở Bảo Hiểm CA theo số 1-800-927-4357. Người dùng TTY gọi số 711. Vietnamese

무료 언어 서비스. 통역사를 통해 사용하시는 언어로 서류를 읽어드립니다. 또한 사용하시는 언어로 자료를 번역해달라고 요청하거나 대체 형식으로 보내달라고 요청하셔도 됩니다. 도움이 필요한 경우, 회원 신분증에 적힌 번호나 1-800-788-0710번으로 문의하십시오. 추가로 도움이 필요한 경우, 캘리포니아주 보험국 전화번호 1-800-927-4357번으로 문의하시기를 바랍니다. TTY 사용자는 711번으로 전화하십시오. Korean

Walang Gastos na Mga Serbisyo sa Wika. Maaari kayong kumuha ng interpreter at ipabasa ang mga dokumento sa inyong wika. Maaari rin kayong humiling na ang mga materyal ay isalin sa inyong wika o ipadala sa inyo sa mga alternatibong format. Para sa tulong, tawagan kami sa numero na nakalista sa inyong card ng pagkakakilanlan o sa 1-800-788-0710. Para sa higit pang tulong tumawag sa Departamento ng Insurance ng California sa 1-800-927-4357. Ang mga gumagamit ng TTY ay dapat tumawag sa 711. Tagalog

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ, և փաստաթղթերը կարող են ընթերցել ձեզ համար ձեր լեզվով: Կարող եք նաև խնդրել, որ նյութերը թարգմանվեն ձեր լեզվով կամ տրամադրվեն ձեզ այլընտրանքային ձևաչափերով: Օգնության համար զանգահարեք մեզ ձեր նույնականացման քարտի վրա նշված համարով կամ 1-800-788-0710 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության վարչություն 1-800-927-4357 հեռախոսահամարով: TTY-ից օգտվողները պետք է զանգահարեն 711: Armenian

Бесплатные услуги переводчика. Вы можете воспользоваться услугами переводчика, и документы будут прочтены для вас на вашем языке. Вы также можете подать запрос о переводе материалов на ваш язык или в альтернативные форматы. Если вам требуется помощь, звоните нам по телефону, указанному на вашей идентификационной карте, или по телефону 1-800-788-0710. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Пользователям TTY следует звонить по телефону 711. Russian

無料の言語サービス。 通訳を手配し、書類をあなたの言語で読み上げてもらうことができます。また、ご希望があれば資料をあなたの言語に翻訳したり、別の形式でお届けすることも可能です。サポートが必要な場合は、身分証明カードに記載されている電話番号、または1-800-788-0710にお電話ください。さらにサポートが必要な場合は、カリフォルニア州保険局まで1-800-927-4357にご連絡ください。TTYユーザーの方は、711までお電話にてご連絡ください。Japanese

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خدمات زبانی رایگان. می‌توانید یک مترجم شفاهی داشته باشید و ترتیبی بدهید تا اسناد به زبان خودتان برای شما خوانده شود. همچنین می‌توانید درخواست کنید که مطالب به زبان شما ترجمه شود یا در قالب‌های جایگزین برای شما ارسال گردد. برای دریافت کمک و راهنمایی، با شماره مندرج در کارت شناسایی یا 1-800-788-0710 با ما تماس بگیرید. برای دریافت راهنمایی بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. کاربران TTY می‌توانند با شماره 711 تماس بگیرند. Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸਹਾਇਤਾ ਨਾਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹਵਾ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਮੱਗਰੀ ਦੇ ਅਨੁਵਾਦ ਜਾਂ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟਾਂ ਦੀ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਸਹਾਇਤਾ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਜਾਂ 1-800-788-0710 'ਤੇ ਕਾਲ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। TTY ਦੇ ਉਪਯੋਗਕਰਤਾ 711 'ਤੇ ਫ਼ੋਨ ਕਰੋ। ਪੰਜਾਬੀ Punjabi

សេវាកាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែនិងទទួលបានឯកសារអានជូនអ្នក ក្នុងភាសារបស់អ្នក។ អ្នកក៏អាចស្នើសុំព័ត៌មានជាច្រើនដើម្បីបកប្រែក្នុងភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀត ត្រូវបានផ្ញើទៅអ្នក។ សម្រាប់ជំនួយ សូមទូរសព្ទមកលេខដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬនៅលេខ 1-800-788-0710។ សម្រាប់ជំនួយបន្ថែម សូមទូរសព្ទទៅនាយកដ្ឋានជានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ាលេខ 1-800-927-4357។ អ្នកប្រើប្រាស់ TTY សូមហៅទៅលេខ 711។ Khmer

خدمات لغوية بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك بلغتك. يجوز لك أيضاً طلب إرسال وثائق مترجمة بلغتك أو صيغ بديلة. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية الخاصة بك أو 1-800-788-0710 . لمزيد من المساعدة اتصل بقسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. على مستخدمي TTY الاتصال على الرقم 711. العربية. Arabic

Kev Pab Txhais Lus Dawb. Koj tuaj yeem txais ib tug kws txhais lus thiab txais kev nyeem cov ntaub ntawv ua koj hom lus. Koj tuaj kheev thov kom muab cov ntaub ntawv txhais mus ua koj hom lus los sis xa ua lwm hom ntawv tuaj rau koj huv si. Yog xav tau kev pab, hu rau nyob ntawm tus xov tooj uas sau nyob rau ntawm koj daim npav cim thawj los sis 1-800-788-0710. Rau kev pab ntxiv, hu rau CA Chaw Ua Hauj Lwm Tswj Kev Tuav Pov Hwm ntawm 1-800-927-4357. Cov neeg siv TTY hu rau 711. Hmong

बिना किसी लागत के भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं और दस्तावेज़ आपको आपकी भाषा में पढ़ कर सुनाए जा सकते हैं। आप सामग्रियों को अपनी भाषा या आपको भेजे जाने वाले वैकल्पिक प्रारूप में अनुवाद करवाने के लिए भी अनुरोध कर सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिये नम्बर या 1-800-788-0710 पर हमें कॉल करें। अधिक सहायता के लिए कैलिफोर्निया डिपार्टमेंट ऑफ इंशोरेंस को 1-800-927-4357 पर कॉल करें। TTY प्रयोक्ता 711 पर कॉल करें। हिंदी: Hindi

บริการด้านภาษาที่ไม่คิดค่าบริการ คุณสามารถขอใช้บริการล่ามและบริการอ่านเอกสารให้ฟังเป็นภาษาของคุณได้ คุณอาจขอเอกสารที่แปลเป็นภาษาของคุณหรือในรูปแบบอื่นที่ส่งถึงคุณได้ หากต้องการความช่วยเหลือ โปรดติดต่อหมายเลขโทรศัพท์ที่ปรากฏบนบัตรประจำตัวของคุณหรือติดต่อหมายเลข 1-800-788-0710 หากต้องการความช่วยเหลือเพิ่มเติม โปรดติดต่อกรมการประกันภัยของรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 ผู้ใช้เครื่อง TTY โปรดติดต่อหมายเลข 711 Thai

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KAISER PERMANENTE®

Kaiser Permanente Insurance Company : **Silver 70 PPO 2500/60 PCP + Child Dental INF**

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.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating Provider Tier: $2,500 Individual / $5,000 Family. Non-Participating Provider Tier: $5,000 Individual / $10,000 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?	Yes. $350 Individual / $700 Family for brand and specialty prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Participating Provider Tier: $9,200 Individual / $18,400 Family. Non-Participating Provider Tier: $18,400 Individual / $36,800 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/dpc/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	$60 / visit, deductible does not apply	40% coinsurance	None.
	Specialist visit	$90 / visit, deductible does not apply	40% coinsurance	None.
	Preventive care/screening/ Immunization	No charge, deductible does not apply	40% coinsurance, deductible does not apply	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: $90 / test, deductible does not apply. Lab tests: $55 / test, deductible does not apply.	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	$300 / procedure	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: $20 / prescription (retail), $40 / 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: $90 / prescription (retail), $180 / prescription (mail order), after drug deductible	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines.
	Non-preferred brand drugs	MedImpact: $90 / prescription (retail), $180 / prescription (mail order), after drug deductible	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines.
	Specialty drugs	MedImpact: 30% coinsurance up to $250 / prescription, after drug deductible	Not covered	Up to a 30-day supply retail. Subject to formulary guidelines.

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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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Coinsurance waived if admitted to hospital as inpatient.
	Emergency medical transportation	40% coinsurance	40% coinsurance	None.
	Urgent care	$60 / visit, deductible does not apply	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% 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	40% coinsurance	50% 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	$60/ individual visit, deductible does not apply. No charge for other outpatient services, deductible does not apply.	40% coinsurance	Participating Provider: $30 / group visit, deductible does not apply
	Inpatient services	40% coinsurance	50% coinsurance	Precertification required (does not apply to emergency admissions and services). Failure to precertify may result in a penalty of up to $500.

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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 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	40% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	40% coinsurance	50% 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.
If you need help recovering or have other special health needs	Home health care	$45 / visit, 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: $60 / visit, deductible does not apply. Inpatient: 40% coinsurance	40% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500.
	Habilitation services	Outpatient: $60/ visit, deductible does not apply. Inpatient: 40% coinsurance	40% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500.
	Skilled nursing care	40% coinsurance	50% 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	40% 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

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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 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
- 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.

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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)

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼1-800-788-0710 (TTY: 711)

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

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-278-3296 (TTY: 711) uff

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-278-3296 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-278-3296 (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)

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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** **$2,500**
- **Specialist copayment** **$90**
- **Hospital (facility) coinsurance** **40%**
- **Other (blood work) copayment** **$55**

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	$2,500
Copayments	$400
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$5,350**

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$90**
- **Hospital (facility) coinsurance** **40%**
- **Other (blood work) copayment** **$55**

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	$1,400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,600**

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$90**
- **Hospital (facility) coinsurance** **40%**
- **Other (*x-ray*) copayment** **$90**

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	$1,900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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