




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 see [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-800-278-3296 (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](http://www.healthcare.gov/sbc-glossary) or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$300 Individual / \$600 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Medical <a href="#">Out-of-Pocket Limit</a> : \$2,000 Individual / \$4,000 Family. <a href="#">Prescription Drug Out-of-Pocket Limit</a> (in- <a href="#">network</a> ): Calendar year 2023: \$6,700/individual, \$13,400/family; Effective 1/1/24 for the 2024 calendar year: \$7,100/individual, \$14,200/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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Medical <a href="#">Out-of-Pocket Limit</a> : <a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2. <a href="#">Prescription Drug Out-of-Pocket Limit</a> (applicable to <a href="#">prescription drugs</a> from <a href="#">network</a> pharmacies): <a href="#">premiums</a> , <a href="#">deductibles</a> , <a href="#">balance billing</a> charges, 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> .

<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) 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 plan's <a href="#">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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	Yes, but you may self-refer to certain <a href="#">specialists</a> .	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> .

 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
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 / visit, <a href="#">deductible</a> does not apply.	Not Covered	None
	<a href="#">Specialist</a> visit	\$20 / visit, <a href="#">deductible</a> does not apply.	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge, <a href="#">deductible</a> does not apply.	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> up to \$50 / procedure	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or call 1-800-788-7871.</p>	Generic drugs	\$12 <a href="#">copay</a> / prescription <a href="#">Deductible</a> does not apply.	Not Covered	<ul style="list-style-type: none"> <li>You must use a Participating Pharmacy listed in the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage.</li> <li>Your <a href="#">cost sharing</a> applies to the <a href="#">prescription drug out-of-pocket limit</a>, not to the medical <a href="#">out-of-pocket limit</a>.</li> <li>Limited to a 30-day supply (90-day supply for maintenance drugs in certain therapeutic classifications).</li> <li>If you purchase a brand drug when a generic drug is available, you pay the brand drug <a href="#">copayment</a> plus the difference in cost between the brand drug and the generic drug unless your <a href="#">provider</a> indicates “dispense as written.”</li> <li>Mail order available only outside California.</li> <li>See the website listed or call 1-800-788-7871 for information on drugs covered by your <a href="#">plan</a>. Not all drugs are covered.</li> </ul>
	<a href="#">Formulary</a> brand drugs (Preferred)	\$30 <a href="#">copay</a> / prescription <a href="#">Deductible</a> does not apply.	Not Covered	
	Non- <a href="#">Formulary</a> brand drugs (Non-Preferred)	\$50 <a href="#">copay</a> / prescription <a href="#">Deductible</a> does not apply	Not Covered	
	<a href="#">Preventive care</a> drugs	No charge. <a href="#">Deductible</a> does not apply.	Not covered	
	Injectable ( <a href="#">Specialty drugs</a> )	20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply.	Not Covered	
				<p>You must use a Participating Pharmacy listed in the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage. You must have a prescription or no coverage. Coverage is for generic drugs only (or brand name if a generic drug is unavailable or medically inappropriate). <a href="#">Preventive care</a> drugs are limited to aspirin, fluoride supplementation, folic acid, colon cancer <a href="#">screening</a> prep products, tobacco cessation medications, statin preventive medication, breast cancer preventive medication (e.g., Tamoxifene), FDA-approved female contraceptives, and pre-exposure prophylaxis (PrEP) for persons at increased risk of HIV acquisition. Age and frequency limits apply.</p> <p><a href="#">Preauthorization</a> from OptumRx is required or no coverage. Call Optum Rx at 800-788-7871.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not Covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	\$150 / trip	\$150 / trip	None
	<a href="#">Urgent care</a>	\$20 / visit, <a href="#">deductible</a> does not apply.	\$20 / visit, <a href="#">deductible</a> does not apply.	<a href="#">Non-Plan providers</a> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not Covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral health: \$20 / individual visit, <a href="#">deductible</a> does not apply. 20% <a href="#">coinsurance</a> for other outpatient services. Substance Abuse: \$20 / individual visit, <a href="#">deductible</a> does not apply. 20% <a href="#">coinsurance</a> up to \$5 / day for other outpatient services, <a href="#">deductible</a> does not apply.	Not Covered	Mental / Behavioral health: \$10 / group visit, <a href="#">deductible</a> does not apply. Substance Abuse: \$5 / group visit, <a href="#">deductible</a> does not apply.
	Inpatient services	20% <a href="#">coinsurance</a>	Not Covered	None
If you are pregnant	Office visits	No Charge, <a href="#">deductible</a> does not apply.	Not Covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not Covered	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan 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, <a href="#">deductible</a> does not apply.	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	<a href="#">Rehabilitation services</a>	Inpatient: 20% <a href="#">coinsurance</a> Outpatient: \$20 / visit	Not Covered	None
	<a href="#">Habilitation services</a>	\$20 / visit	Not Covered	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not Covered	Up to 100 days maximum / benefit period.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	Not Covered	Requires prior authorization.
	<a href="#">Hospice services</a>	No Charge, <a href="#">deductible</a> does not apply.	Not Covered	None
If your child needs dental or eye care	Children's eye exam	<b>Kaiser:</b> No charge, <a href="#">deductible</a> does not apply. <b>Trust Fund:</b> No charge. <a href="#">Deductible</a> does not apply.	<b>Kaiser:</b> Not Covered <b>Trust Fund:</b> No charge. <a href="#">Deductible</a> does not apply.	<b>Trust Fund:</b> Maximum benefit of \$135 per exam.
	Children's glasses	<b>Kaiser:</b> Not Covered <b>Trust Fund:</b> You pay all charges over the Fund's allowance. <a href="#">Deductible</a> does not apply.	<b>Kaiser:</b> Not Covered <b>Trust Fund:</b> You pay all charges over the Fund's allowance. <a href="#">Deductible</a> does not apply.	<b>Trust Fund:</b> <a href="#">Allowed amount</a> of \$135 per year is reduced by the cost of eye exam(s) paid by the Fund. Pediatric vision benefits are for children up to 19 years. Unused vision benefits from 2023 roll over for use in 2024.
	Children's dental check-up	<b>Kaiser:</b> Not Covered <b>Trust Fund:</b> You may elect dental coverage from the Indemnity Dental <a href="#">Plan</a> or the United Concordia Dental HMO.		Your dental coverage is not subject to health care reform.

### Excluded Services & Other Covered Services:

<b>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>.)</b>		
<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care (Fund provides limited benefit of up to \$120 per calendar year)</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 ([plan provider](#) referred)
- Bariatric surgery
- Dental care (Adult) (available under separate Indemnity Dental [Plan](#) or United Concordia Dental HMO)
- Hearing aids (maximum benefit of \$750 for each ear in a 12-month period, payable through the Fund.)
- Infertility treatment
- Routine eye care (Adult) (Coverage for glasses and contacts is limited to Fund-provided benefit of \$135/year for exam, frames, and lenses)

**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](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 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	1-800-278-3296 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>
California Department of Insurance	1-800-927-HELP (4357) or <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a>
California Department of Managed Healthcare	1-888-466-2219 or <a href="http://www.healthhelp.ca.gov/">www.healthhelp.ca.gov/</a>

**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 1-800-788-0616 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-757-7585 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 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.*

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other (blood work) <a href="#">copayment</a>	\$10

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>	\$300
<a href="#">Copayments</a>	\$50
<a href="#">Coinsurance</a>	\$1,660

*What isn't covered*

Limits or exclusions	\$20
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<b>The total Peg would pay is</b>	<b>\$2,030</b>
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### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other (blood work) <a href="#">copayment</a>	\$10

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>	\$120
<a href="#">Copayments</a>	\$960
<a href="#">Coinsurance</a>	\$100

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Joe would pay is</b>	<b>\$1,180</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other (x-ray) <a href="#">copayment</a>	\$10

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>	\$300
<a href="#">Copayments</a>	\$340
<a href="#">Coinsurance</a>	\$200

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$840</b>
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\*\*Note: The Patient Pays amount is capped at the [plan's out-of-pocket limit](#). Total amounts may not add up due to rounding.

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