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, go to www.meritain.com or call PHR Shared Services at (877) 608-0044. 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 Meritain Health, Inc. at (888) 711-7876 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating and non-participating providers: $50 person / $100 family (Retired SCPMG Partner Physicians); $100 person / $200 family (Retired Associate Physicians and Retired NPG's defined as: Podiatrist, Senior Leaders, Non Physician Executives and Oral Surgeons)	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 participating providers: Hospice services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 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 (You will pay the least)	Non-Participating 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	Not Covered	Not Covered	----------none----------
	Specialist visit	Not Covered	Not Covered	
	Preventive care/screening/ immunization	Not Covered	Not Covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	20% coinsurance	20% coinsurance	Major medical deductible applies. The copay applies per prescription. Prescription drugs prescribed in connection with services not normally provided by Kaiser Foundation Health Plan. Specialty drugs will be handled by Accredo.
	Brand name drugs	20% coinsurance	20% coinsurance	
	Specialty drugs	20% coinsurance	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	----------none----------
	Physician/surgeon fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	----------none----------
	Emergency medical transportation	Not Covered	Not Covered	
	Urgent care	Not Covered	Not Covered	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	----------none----------
	Physician/surgeon fees	Not Covered	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	KFHP denial letter required.
	Inpatient services	20% coinsurance	20% coinsurance	KFHP denial letter required.
If you are pregnant	Office visits	Not Covered	Not Covered	----------none----------
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	50% coinsurance (custodial care only)	50% coinsurance (custodial care only)	KFHP denial letter required. Evidence of total & permanent disability required.
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes physical, speech, and occupational therapies. The plan will check for medical necessity after 20 visits for each therapy per calendar year. KFHP denial letter required.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% coinsurance/ 50% coinsurance (custodial)	20% coinsurance/ 50% coinsurance (custodial)	KFHP denial letter required.
	Durable medical equipment	20% coinsurance	20% coinsurance	KFHP denial letter required.
	Hospice services	No Charge	No Charge	Outpatient limited to 100 visits. Emotional support limited to $50 per day. Services of a social worker limited to 1 visit per 7 day period, $50 per day. Bereavement counseling limited to $50 per day, limited to 6 visits within 12 months following death. Transportation limited to $25 per day, $100 per lifetime. KFHP denial letter required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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.)

- Ambulance transportation
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Emergency room services
- Glasses (Adult & Child)
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S. (except for business)
- Private-duty nursing (except for hospice)
- Routine eye care (Adult & Child)
- Routine foot care (except for metabolic or peripheral vascular disease)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care ($1,000 per year for non-partner retirees)
- Infertility treatment ($30,000 per lifetime for non-partner retirees)
- TMJ treatment ($2,000 per lifetime for non-partner retirees)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or PHR Shared Services at (877) 608-0044. 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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or PHR Shared Services at (877) 608-0044. Additionally, a consumer assistance program can help you file your appeal. Contact the California Consumer Assistance Program, operated by the California Department of Insurance at (800) 927-4357.

Does this plan provide Minimum Essential Coverage? No

While these plans do not meet minuimum essential coverage, your underlying primary plan through KFHP may. Please refer to your Kaiser SBC for additional detail.

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? No

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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

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 plan's overall deductible	**$100**
Primary care physician coinsurance	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician 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	$29
Copayments	$0
Coinsurance	$7
What isn't covered	
Limits or exclusions	$12,695
The total Peg would pay is	$12,731

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

The plan's overall deductible	**$100**
Specialist coinsurance	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist 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	$100
Copayments	$0
Coinsurance	$852
What isn't covered	
Limits or exclusions	$3,132
The total Joe would pay is	$4,083

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

The plan's overall deductible	**$100**
Specialist coinsurance	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**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	$100
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or exclusions	$1,673
The total Mia would pay is	$1,823

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