**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 or call 1- 866-213-3062 or 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 1-866-213-3062 or TTY 711 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $2,800 Individual / $5,600 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 services 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, but see the chart starting on page 2 for other costs for services this plan covers. |
| **What is the out-of-pocket limit for this plan?** | $4,000 Individual/ $8,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balanced-billed charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.kp.org or call 1-866-213-3062 or TTY 711 for a list of plan 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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 30% Coinsurance | Not Covered | None |
| | Specialist visit | 30% Coinsurance | Not Covered | None |
| | Preventive care/screening / immunization | No Charge, deductible does not apply | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | X-ray: 30% Coinsurance<br>Lab: 30% Coinsurance | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 30% Coinsurance | Not Covered | None |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.kp.org | Generic drugs | Retail: $20 Copay; Mail Order: $40 Copay | Not Covered | Subject to formulary guidelines. Preventive Drugs on the KP Preventive Drug list at No Charge. Non-preferred brand drugs must be authorized through the non- preferred drug process. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 30- day supply (retail prescription); 31-90 day supply (mail order prescription). |
| | Preferred brand drugs | Retail: $40 Copay;<br>Mail Order: $80 Copay | Not Covered | |
| | Non-preferred brand drugs | Retail: $60 Copay;<br>Mail Order: $120 Copay | Not Covered | |
| | Specialty drugs | 30% Coinsurance | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% Coinsurance | Not Covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | 30% Coinsurance | Not Covered | None |
| **If you need immediate medical attention** | Emergency room care | 30% Coinsurance | 30% Coinsurance | None |
| | Emergency medical transportation | 30% Coinsurance | 30% Coinsurance | None |
| | Urgent care | 30% Coinsurance | 30% Coinsurance | Non-Plan providers covered when temporarily outside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% Coinsurance | Not Covered | None |
| | Physician/surgeon fees | 30% Coinsurance | Not Covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 30% Coinsurance | Not Covered | None |
| | Inpatient services | 30% Coinsurance | Not Covered | None |
| **If you are pregnant** | Office visits | 30% Coinsurance | Not Covered | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e.ultrasound.) |
| | Childbirth/delivery professional services | 30% Coinsurance | Not Covered | None |
| | Childbirth/delivery facility services | 30% Coinsurance | Not Covered | None |
| **If you need help recovering or have other special health needs** | Home health care | 30% Coinsurance | Not Covered | Limited to less than 8 hours / day and 28 hours / week. |
| | Rehabilitation services | Inpatient services: 30% Coinsurance<br>Outpatient services: 30% Coinsurance | Not Covered | Inpatient: Multi-disciplinary facility limited to 60 days / condition / year.<br>Outpatient: 60 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit). |
| | Habilitation services | 30% Coinsurance | Not Covered | Outpatient: 60 visit limit / therapy year (autism spectrum disorders are not subject to the visit limit). |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Skilled nursing care | 30% Coinsurance | Not Covered | 100 day limit / year. |
| | Durable medical equipment | 30% Coinsurance | Not Covered | Subject to formulary guidelines. Prosthetic arms and legs at 20% Coinsurance. |
| | Hospice services | 30% Coinsurance | Not Covered | None |
| **If your child needs dental or eye care** | Children's eye exam | 30% Coinsurance for refractive exam | Not Covered | For services with an ophthalmologist see "Specialist visit". |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | None |

## 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental care (Adult and child)
- Infertility treatment
- Long Term Care/Custodial Nursing Home Care
- Non-emergency care when traveling outside the US
- 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.)**

- Chiropractic care
- Hearing aids (Up to age 18)
- Private Duty Nursing
- 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 | 1-866-213-3062 (TTY: 711) or www.kp.org/cuhealthplan |
| 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 |

**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 1-866-213-3062 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-213-3062 (TTY: 711)

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-213-3062 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-213-3062 (TTY: 711)

Your health benefits will be self-insured by your Plan Sponsor. Kaiser Permanente Insurance Company will provide certain administrative services for the Plan and will not be an insurer of the Plan or financially liable for health care benefits under the Plan.

*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 | $2,800 |
| Specialist Coinsurance | 30% |
| Hospital (facility) Coinsurance | 30% |
| Other Coinsurance | 30% |

**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 | $2,800 |
| Copayments | $0 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,060** |

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

| | |
|---|---|
| The plan's overall deductible | $2,800 |
| Specialist Coinsurance | 30% |
| Hospital (facility) Coinsurance | 30% |
| Other Coinsurance | 30% |

**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 | $2,800 |
| Copayments | $200 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,120** |

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

| | |
|---|---|
| The plan's overall deductible | $2,800 |
| Specialist Coinsurance | 30% |
| Hospital (facility) Coinsurance | 30% |
| Other Coinsurance | 30% |

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

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