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 or summary plan description, visit www.livethehealthyorangelife.com or call 1-800-555-4954. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-555-4954 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** individual/ **$3,000** 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. The deductible doesn't apply to preventive care, diagnostic tests, emergency services or prescription drugs.	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/preventivecarebenefits/
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?	**$4,500** individual/ **$9,000** 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, balance billing charges, health care this plan doesn't cover and cost sharing for certain services listed in plan documents.	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. Log on at www.kaiserpermanente.com or call 1-855-9KAISER for a list of in-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	No	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a specialist?		

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	$25 copay/visit; deductible does not apply	Not covered	20% coinsurance for covered services received during a visit which count toward the out-of-pocket limit
	Specialist visit	$50 copay/visit; deductible does not apply	Not covered	20% coinsurance for covered services received during a visit which count toward the out-of-pocket limit
	Preventive care/screening/ immunization	No charge	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: 20% coinsurance; deductible does not apply Lab: No charge after applicable office visit copay in office or freestanding center	Not covered	Diagnostic lab services: not subject to the overall deductible except when provided in the outpatient department of a hospital; 20% coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	20% coinsurance; deductible does not apply	Not covered	----------none----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.livethehealthyorang	Generic drugs	Retail: 20% coinsurance up to $20 max per prescription; 30-day supply Mail order: 20% coinsurance up to $20 max per prescription; 90 day supply through	Not covered	No charge for contraceptives. For Southern Colorado members: Prescriptions for second and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Subject to formulary guidelines.

[* For more information about limitations and exceptions, see the plan or policy document at www.livethehealthyorangelife.com.]

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)	
elife.com or call 1-855-9KAISER		KP pharmacies; deductible does not apply		
	Preferred brand drugs	Retail: 20% coinsurance up to $100 max per prescription; 30-day Mail order: 20% coinsurance up to $100 max per prescription; 90 day supply through KP pharmacies	Not covered	
	Non-preferred brand drugs	Not covered unless medically necessary	Not covered	Subject to formulary guidelines.
	Specialty drugs	Retail: $100 copay per prescription/fill; 30-day supply; deductible does not apply	Not covered	Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	----------none----------
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	----------none----------
If you need immediate medical attention	Emergency room care	20% coinsurance; deductible does not apply		This cost sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "If you have a hospital stay" for inpatient cost sharing)
	Emergency medical transportation	20% coinsurance; deductible does not apply		----------none----------
	Urgent care	$50 copay per visit at designated KP Medical Centers; deductible does not apply		Non-participating provider urgent care covered only if you are temporarily outside the service area. If you receive services in addition to an office visit, additional copays, deductible, or coinsurance may apply
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	----------none----------

[* For more information about limitations and exceptions, see the plan or policy document at www.livethehealthyorangelife.com.]

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	20% coinsurance after deductible	Not covered	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit individual; $12 copay per visit group. Deductible does not apply. For substance abuse services, $25 copay per individual visit, $5 copay per group visit. Deductible does not apply.	Not covered	----------none----------
	Inpatient services	20% coinsurance after deductible	Not covered	Preauthorization required
If you are pregnant	Office visits	20% coinsurance after deductible	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	20% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance; deductible does not apply	Not covered	Limited to 120 visits per year
	Rehabilitation services	20% coinsurance; deductible does not apply See Facility fee under "If you have a hospital stay" for inpatient services	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	20% coinsurance; deductible does not apply	Not covered	Limited to 20 visits per therapy per year; Limited to services to maintain/ improve skills or functioning at risk due to medical deficits.

[* For more information about limitations and exceptions, see the plan or policy document at www.livethehealthyorangelife.com.]

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	20% coinsurance after deductible	Not covered	Limited to 100 days per year
	Durable medical equipment	20% coinsurance; deductible does not apply	Not covered	Prosthetic arms and legs not to exceed 20% coinsurance.
	Hospice services	No charge after deductible	Not covered	----------none----------
If your child needs dental or eye care	Children's eye exam	$25 copay per refractive exam; deductible does not apply	Not covered	For ophthalmologist services, see "Specialist visit".
	Children's glasses	Glasses not covered	Not covered	----------none----------
	Children's dental check-up	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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Glasses

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

- Bariatric surgery, subject to pre-approval
- Chiropractic care (limited to 25 visits)
- Hearing aids
- Infertility treatment (in vitro fertilization and fertility drugs are not covered)
- 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 U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. 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: 1-855-952-4737; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform; or the State Department of

[* For more information about limitations and exceptions, see the plan or policy document at www.livethehealthyorangelife.com.]

Insurance at:

Colorado Divisions of Insurance, Consumer Affairs Section
1560 Broadway, Suite 850
Denver, CO 80202 303-894-7490 or 800-930-3745
insurance@dora.state.co.us

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 1-800-555-4954.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-555-4954.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-555-4954.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-555-4954.]

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

[* For more information about limitations and exceptions, see the plan or policy document at www.livethehealthyorangelife.com.]

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	$1,500
Specialist copayments	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,500
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,760**

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

The plan's overall deductible	$1,500
Specialist copayments	$50
Hospital (facility) coinsurance	20%
Othercoinsurance	20%

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	$300
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	$1,500
Specialist copayments	$50
Hospital (facility) coinsurance	20%
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	$40
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$740**

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