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?	**$3,000** individual/ **$3,000** one member in family/ **$6,000** 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 or preventive 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?	**$6,000** individual/**$6,000** one member in a family/ **$12,000** 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	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you

Important Questions	Answers	Why This Matters:
see a specialist?		have a referral before you see the 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	30% coinsurance after deductible	Not covered	----------none----------
	Specialist visit	30% coinsurance after deductible	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)	30% coinsurance after deductible	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	Not Covered	Preauthorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.livethehealthyorangelife.com or 1-855-9KAISER	Generic drugs	Retail or Mail Order: 30% coinsurance up to $20 after deductible; up to a 100-day supply at plan pharmacies	Not covered	In accordance with formulary guidelines, certain drugs may be covered at a different cost share. No charge for contraceptives. Applicable preventive prescription drugs covered 100%, not subject to deductible. Subject to formulary guidelines.
	Preferred brand drugs	Retail or Mail Order: 30% coinsurance up to $100 after deductible; up to a 100-day supply at plan pharmacies	Not covered	In accordance with formulary guidelines, certain drugs may be covered at a different cost share. No charge for contraceptives. Applicable preventive prescription drugs covered 100%, not subject to deductible. Subject to formulary guidelines.
	Non-preferred brand drugs	Not covered unless medically necessary	Not covered	Same as formulary brand drugs when approved through exception process. Applicable preventive prescription drugs covered 100%, not subject to deductible. Subject to formulary guidelines.

[* For more information about limitations and exceptions, see the plan or policy document at 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)	
	Specialty drugs	$200 copay per script after deductible, when deemed medically necessary prescribed by a plan physician and obtained at plan pharmacies.	Not covered	Applicable preventive prescription drugs covered 100%, not subject to deductible. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Not Covered	----------none----------
	Physician/surgeon fees	30% coinsurance after deductible	Not Covered	----------none----------
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible		Non-emergency use of emergency room is not covered
	Emergency medical transportation	30% coinsurance after deductible		----------none----------
	Urgent care	30% coinsurance after deductible		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)	30% coinsurance after deductible	Not covered	----------none----------
	Physician/surgeon fees	30% coinsurance after deductible	Not covered	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance after deductible	Not covered	----------none----------
	Inpatient services	30% coinsurance after deductible	Not covered	----------none----------
If you are pregnant	Office visits	Prenatal care: No charge, deductible does not apply Postnatal care: No charge after deductible	Not covered	Depending on the type of services, coinsurance and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery	30% coinsurance after	Not covered	Cost sharing does not apply for preventive

[* For more information about limitations and exceptions, see the plan or policy document at 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)	
	professional services	deductible		services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	30% 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.)
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per calendar year.
	Rehabilitation services	30% coinsurance after deductible	Not covered	----------none----------
	Habilitation services	30% coinsurance after deductible	Not covered	----------none----------
	Skilled nursing care	30% coinsurance after deductible	Not covered	Up to a 100 day maximum per benefit period.
	Durable medical equipment	30% coinsurance after deductible	Not covered	Preauthorization required
	Hospice services	No charge after deductible	Not covered	----------none----------
If your child needs dental or eye care	Children's eye exam	30% coinsurance for refractive exam; deductible does not apply	Not covered	----------none----------
	Children's glasses	Glasses not covered	Not covered	----------none----------
	Children's dental check-up	Dental check-up not covered	Not covered	----------none----------

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

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.)		
• Cosmetic surgery • Dental care (Adult) • Glasses • Hearing aids	• Infertility treatment • 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 (plan provider referred) • Bariatric surgery, subject to pre-approval	• Chiropractic care (limited to 30 visits)	• 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 Insurance at:

California Department of Insurance
1-800-927-HELP(4357)
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.

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.

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

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.

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[* For more information about limitations and exceptions, see the plan or policy document at 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	$3,000
Specialist copay	30%
Hospital (facility) coinsurance	30%
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	$3,000
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,160**

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

The plan's overall deductible	$3,000
Specialist copay	30%
Hospital (facility) coinsurance	30%
Other coinsurance	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	$3,000
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,720**

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

The plan's overall deductible	$3,000
Specialist copay	30%
Hospital (facility) coinsurance	30%
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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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