




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](http://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 <a href="#">deductible</a> ?	<b>\$2,250</b> individual/ <b>\$4,500</b> 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. The <a href="#">deductible</a> doesn't apply to <a href="#">preventive care</a> or <a href="#">prescription drugs</a> .	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/preventivecarebenefits/">https://www.healthcare.gov/coverage/preventivecarebenefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$4,500</b> individual/ <b>\$9,000</b> 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Log on at <a href="http://www.kaiserpermanente.com">www.kaiserpermanente.com</a> or call 1-855-9KAISER for a list of in- <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">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 provider's 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply	Not covered	Per Senate Bill 1529: Primary care visit – \$5 Copay (not subject to Plan Deductible) for first 3 visits per year. First 3 visits are any combination of Primary Care non-specialty medical Services, Mental Health outpatient Services, Naturopathic medicine visits, Substance Use Disorder outpatient Services, or Telemedicine Services.
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply	Not covered	Some specialists require a <a href="#">referral</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge	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 you need 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)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	No charge for <a href="#">preventive care</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----none-----
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.livethehealthyorangelifelife.com">www.livethehealthyorangelifelife.com</a> or 1-855-9KAISER	Generic drugs	Retail: 20% <a href="#">coinsurance</a> up to \$5 max per prescription; 30-day supply at KP pharmacies Mail order: 20% <a href="#">coinsurance</a> up to \$10 max per prescription; 90-day supply. <a href="#">Deductible</a> does not apply	Not covered	No charge for contraceptives. Subject to <a href="#">formulary</a> guidelines.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.livethehealthyorangelifelife.com](http://www.livethehealthyorangelifelife.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)	
	Preferred brand drugs	Retail: 20% <a href="#">coinsurance</a> up to \$100 max per prescription; 30-day supply at KP pharmacies Mail order: 20% <a href="#">coinsurance</a> up to \$200 max per prescription; 90-day supply. <a href="#">Deductible</a> does not apply	Not covered	
	Non-preferred brand drugs	Not covered unless medically necessary	Not covered	Covered same as Preferred brand drugs, only if <a href="#">medically necessary</a> . Subject to <a href="#">formulary</a> guidelines.
	<a href="#">Specialty drugs</a>	Retail: \$100 <a href="#">copay</a> per prescription; up to 30-day supply. <a href="#">Deductible</a> does not apply	Not covered	Subject to <a href="#">formulary</a> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----none-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply		-----none-----
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		-----none-----
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> per visit; <a href="#">deductible</a> does not apply		Non-participating provider <a href="#">urgent care</a> covered only if you are temporarily outside the service area. If you receive services in addition to an office visit, additional <a href="#">copays</a> , <a href="#">deductible</a> , or <a href="#">coinsurance</a> may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----none-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----none-----

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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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$10 <a href="#">copay</a> per visit individual; \$5 <a href="#">copay</a> per visit group. <a href="#">Deductible</a> does not apply	Not covered	Per Senate Bill 1529: Primary care visit – \$5 Copay (not subject to Plan Deductible) for first 3 visits per year. First 3 visits are any combination of Primary Care non-specialty medical Services, Mental Health outpatient Services, Naturopathic medicine visits, Substance Use Disorder outpatient Services, or Telemedicine Services.
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	-----none-----
<b>If you are pregnant</b>	Office visits	No charge	Not covered	Depending on the type of services, a <a href="#">copay</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> after <a href="#">deductible</a>	Not covered	<a href="#">Cost sharing</a> does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Cost sharing</a> does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Limited to 120 days per year
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Preauthorization</a> required; limited to 20 visits per therapy per calendar year.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Coverage is limited to neurodevelopmental disorders of early childhood. <a href="#">Preauthorization</a> required; limited to 20 visits per therapy per calendar year.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Limited to 100 days per year
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Medicare criteria apply.

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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)	
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Preauthorization</a> required.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 copay per refractive exam; <a href="#">deductible</a> does not apply	Not covered	For ophthalmologist services, see " <a href="#">Specialist visit</a> ".
	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 <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> .)		
<ul style="list-style-type: none"> <li>Acupuncture (self-referred)</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Glasses</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S</li> <li>Private-duty nursing</li> <li>Routine foot care</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 <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Bariatric surgery, subject to pre-approval</li> <li>Chiropractic care (limited to 25 visits, does not count toward out-of-pocket maximum)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>

**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](http://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](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: 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](http://www.dol.gov/ebsa/healthreform); or the State Department of Insurance at:

Oregon Insurance Division, P.O. Box 14480  
Salem, OR 97309-0405, 503-947-7984  
<http://www.cbs.state.or.us/ins/index.html>  
cp.ins@state.or.us

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### 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, kwijigo 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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## 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>	\$2,250
■ <a href="#">Specialist copayments</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,810</b>

### 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>	\$2,250
■ <a href="#">Specialist copayments</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,250
■ <a href="#">Specialist copayments</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,400</b>

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