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?	**$0**	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	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?	**$2,500** individual/ **$7,500** 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, 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. 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 see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you 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	$15 copay per visit; No charge for outpatient pediatric	Not covered	----------none----------
	Specialist visit	$15 copay per visit	Not covered	----------none----------
	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)	No charge	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	----------none----------
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: $5 copay per prescription (maintenance); $10 copay per prescription (generic); 30-day supply Mail order: $10 copay per prescription (maintenance); $20 copay per prescription (generic); 90 day supply.	Not covered	No charge for contraceptives (subject to formulary guidelines). Subject to formulary guidelines.
	Preferred brand drugs	Retail: $35 copay per prescription; 30-day supply Mail order: $70 copay per prescription; 90 day supply	Not covered	
	Non-preferred brand drugs	Not covered unless	Not covered	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)	
		medically necessary		
	Specialty drugs	Retail: $75 copay per prescription; 30-day supply	Not covered	Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$15 copay per visit	Not covered	----------none----------
	Physician/surgeon fees	$15 copay per visit	Not covered	----------none----------
If you need immediate medical attention	Emergency room care	$75 copay per visit		Must notify KP within 48 hours if admitted to a non-plan provider
	Emergency medical transportation	20% coinsurance; deductible does not apply		----------none----------
	Urgent care	$15 copay per visit at KP HI facilities; 20% coinsurance for non-KP facility outside HI service area		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)	$75 copay per day	Not covered	----------none----------
	Physician/surgeon fees	$75 copay per day	Not covered	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay per day	Not covered	----------none----------
	Inpatient services	$75 copay per day	Not covered	----------none----------
If you are pregnant	Office visits	No charge	Not covered	$15 copay initial visit to confirm pregnancy. Limited to routine care. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge for delivery (included in facility fee); $75 copay per day for	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)	
		inpatient newborn care		
	Childbirth/delivery facility services	No charge for delivery	Not covered	$75 copay per day for inpatient newborn care
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	----------none----------
	Rehabilitation services	$15 copay per visit (outpatient); $75 copay per day (inpatient)	Not covered	----------none----------.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	No charge	Not covered	120 day maximum per accumulation period
	Durable medical equipment	20% coinsurance for durable medical equipment and external prosthetics; 100% covered for internal prosthetics	Not covered	50% coinsurance for Diabetic Equipment. Breast pump rental fee covered at 100%
	Hospice services	No charge	Not covered	Includes two 90 day periods, followed by unlimited number of 60 day periods
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	----------none----------
	Children's glasses	No charge	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
- 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

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
- Glasses
- Infertility treatment
- 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

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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:

State Hawaii Department of Commerce and Consumer Affairs:
Hawaii Insurance Division Health Insurance Branch
PO Box 3614
Honolulu, HI 96811

1-808-586-2804

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.

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[* 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	**$0**
Specialist copayments	**$15**
Hospital (facility) copayments	**$75**
Other copayments	**$75**

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	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$260**

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

The plan's overall deductible	**$0**
Specialist copayments	**$15**
Hospital (facility) copayments	**$75**
Other copayments	**$75**

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	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	**$0**
Specialist copayments	**$15**
Hospital (facility) copayments	**$75**
Other copayments	**$75**

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	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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