




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.livethehealthyorangelifelife.com](http://www.livethehealthyorangelifelife.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> ?	\$0	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>	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> ?	\$2,500 individual/ \$7,500 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 <a href="#">in-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, but you may self-refer to certain <a href="#">specialists</a> .	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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> per visit; No charge for outpatient pediatric	Not covered	-----none-----
	<a href="#">Specialist</a> visit	\$15 <a href="#">copay</a> per visit	Not covered	-----none-----
	<a href="#">Preventive care/screening/</a> immunization	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.
If you have a test	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.livethehealthyorangelife.com">www.livethehealthyorangelife.com</a> or 1-855-9KAISER	Generic drugs	Retail: \$5 <a href="#">copay</a> per prescription (maintenance); \$10 <a href="#">copay</a> per prescription (generic); 30-day supply Mail order: \$10 <a href="#">copay</a> per prescription (maintenance); \$20 <a href="#">copay</a> per prescription (generic); 90 day supply.	Not covered	No charge for contraceptives (subject to <a href="#">formulary</a> guidelines). Subject to <a href="#">formulary</a> guidelines.
	Preferred brand drugs	Retail: \$35 <a href="#">copay</a> per prescription; 30-day supply Mail order: \$70 <a href="#">copay</a> per prescription; 90 day supply	Not covered	
	Non-preferred brand drugs	Not covered unless	Not covered	Subject to <a href="#">formulary</a> guidelines.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.livethehealthyorangelife.com](http://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)	
		<a href="#">medically necessary</a>		
	<a href="#">Specialty drugs</a>	Retail: \$75 <a href="#">copay</a> per prescription; 30-day supply	Not covered	Subject to <a href="#">formulary</a> guidelines.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$15 <a href="#">copay</a> per visit	Not covered	-----none-----
	Physician/surgeon fees	\$15 <a href="#">copay</a> per visit	Not covered	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$75 <a href="#">copay</a> per visit		Must notify KP within 48 hours if admitted to a non- <a href="#">plan provider</a>
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>		-----none-----
	<a href="#">Urgent care</a>	\$15 <a href="#">copay</a> per visit at KP HI facilities; 20% <a href="#">coinsurance</a> for non-KP facility outside HI service area		Non-participating <a href="#">provider 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
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$75 <a href="#">copay</a> per day	Not covered	-----none-----
	Physician/surgeon fees	\$75 <a href="#">copay</a> per day	Not covered	-----none-----
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <a href="#">copay</a> per day	Not covered	-----none-----
	Inpatient services	\$75 <a href="#">copay</a> per day	Not covered	-----none-----
<b>If you are pregnant</b>	Office visits	No charge	Not covered	\$15 <a href="#">copay</a> initial visit to confirm pregnancy. Limited to routine care. 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	No charge for delivery (included in facility fee); \$75 <a href="#">copay</a> per day for	Not covered	-----none-----

[\* 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)	
		inpatient newborn care		
	Childbirth/delivery facility services	No charge for delivery	Not covered	\$75 <a href="#">copay</a> per day for inpatient newborn care
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not covered	-----none-----
	<a href="#">Rehabilitation services</a>	\$15 <a href="#">copay</a> per visit	Not covered	-----none-----
	<a href="#">Habilitation services</a>	Not covered	Not covered	-----none-----
	<a href="#">Skilled nursing care</a>	No charge	Not covered	120 day maximum per calendar year
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> for durable medical equipment and external prosthetics; 100% covered for internal prosthetics	Not covered	50% <a href="#">coinsurance</a> for Diabetic Equipment. Breast pump rental fee covered at 100%
	<a href="#">Hospice services</a>	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 <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</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S</li> </ul>	<ul style="list-style-type: none"> <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 30 visits)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Glasses</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <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.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.livethehealthyorangelife.com](http://www.livethehealthyorangelife.com).]

**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:

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, 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>	\$0
■ <a href="#">Specialist copayments</a>	\$15
■ Hospital (facility) <a href="#">copayments</a>	\$75
■ Other <a href="#">copayments</a>	\$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*)

<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>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$260</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>	\$0
■ <a href="#">Specialist copayments</a>	\$15
■ Hospital (facility) <a href="#">copayments</a>	\$75
■ Other <a href="#">copayments</a>	\$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*)

<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>	\$700
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$920</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>	\$0
■ <a href="#">Specialist copayments</a>	\$15
■ Hospital (facility) <a href="#">copayments</a>	\$75
■ Other <a href="#">copayments</a>	\$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*)

<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>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

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