**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?** | **$2,250** individual/ **$4,500** 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** | 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<br>Network Provider (You will pay the least) | What You Will Pay<br>Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $10 copay/visit; deductible does not apply | Not covered | ----------none---------- |
| | Specialist visit | $35 copay/visit; deductible does not apply | 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) | 20% coinsurance, deductible does not apply | Not covered | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance, deductible does not apply | Not covered | ----------none---------- |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.livethehealthyorangelife.com or call 1-855-9KAISER | Generic drugs | Retail: 20% coinsurance up to $5 max per prescription, deductible does not apply; up to a 100-day supply at plan pharmacies.<br>Mail Order: 20% coinsurance up to $5 max per prescription, deductible does not apply; up to a 100-day | Not covered | No charge for contraceptives. 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<br>Network Provider (You will pay the least) | What You Will Pay<br>Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | supply at plan pharmacies. | | |
| | Preferred brand drugs | Retail: 20% coinsurance up to $100 max per prescription, deductible does not apply; up to a 100-day supply at plan pharmacies.<br>Mail Order: 20% coinsurance up to $100 max per prescription, deductible does not apply; up to a 100-day supply at plan pharmacies. | Not covered | Certain drugs may be covered at a different cost share. No charge for contraceptives. 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. Subject to formulary guidelines. |
| | Specialty drugs | $100 copay per prescription per fill, deductible does not apply; up to a 30-day supply when deemed medically necessary prescribed by a plan physician and obtained at plan pharmacies. | 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 | | ----------none---------- |
| | Emergency medical transportation | 20% coinsurance after deductible | | ----------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<br>Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | Urgent care | $10 copay per visit, 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 | Preauthorization required |
| | Physician/surgeon fees | 20% coinsurance after deductible | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $10 copay per visit individual; $5 copay per visit group. Deductible does not apply | Not covered | ----------none---------- |
| | Inpatient services | 20% coinsurance after deductible | Not covered | Preauthorization required |
| **If you are pregnant** | Office visits | No charge; deductible does not apply | Not covered | 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 | 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.) In compliance with state law, doula services are covered and subject to certain limitations. |
| | Childbirth/delivery facility services | 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.) |
| **If you need help** | Home health care | No charge; deductible does not apply | Not covered | Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 120 visits maximum per calendar year. |

| | | | | |
|---|---|---|---|---|
| **recovering or have other special health needs** | Rehabilitation services | Inpatient: 20% coinsurance after deductible<br>Outpatient: $10 copay | Not covered | ----------none---------- |

| Common Medical Event | Services You May Need | What You Will Pay<br>Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | per day, deductible does not apply | | |
| | Habilitation services | $10 copay per day, deductible does not apply | Not covered | ----------none---------- |
| | Skilled nursing care | 20% coinsurance after deductible | Not covered | Up to a 100 day maximum per benefit period. |
| | Durable medical equipment | 20% coinsurance; deductible does not apply | Not covered | Preauthorization required |
| | Hospice services | No charge; deductible does not apply | Not covered | ----------none---------- |
| **If your child needs dental or eye care** | Children's eye exam | No charge 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---------- |

## 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
- 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)
- Hearing aids
- 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

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

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.

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

**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.*

## 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** **$2,250**
- **Specialist copayments** **$35**
- **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 | $2,250 |
| Copayments | $0 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,810** |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,250**
- **Specialist copayments** **$35**
- **Hospital (facility) coinsurance** **20%**
- **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 | $0 |
| Copayments | $200 |
| Coinsurance | $900 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,120** |

### Mia's Simple Fracture

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

- **The plan's overall deductible** **$2,250**
- **Specialist copayments** **$35**
- **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 | $1,000 |
| Copayments | $100 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,400** |

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