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, see www.Kp.org/plandocuments or call 1-855-249-5005 or TTY 711. 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 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500**/Individual, **$1,000**/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, preventive services, certain services with copays, prescription drugs and hospice.	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/preventive-care-benefits.
Are there other deductibles for specific services?	**$50**/person dental deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$2,500**/Individual, **$5,000**/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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, dental and vision expenses, 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. See www.Kp.org or call 1-855-249-5005 or TTY 711 for a list of plan 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialist..	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
		Plan Provider (You will pay the least)	Non-Plan 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	$25 copay per visit; 20% coinsurance for covered services received during a visit. Phone visit: No charge; Chat/online visit: No charge; Video visit: No charge. Deductible does not apply to copay	Not covered	None.
	Specialist visit	$35 copay per visit; 20% coinsurance for covered services received during a visit. Phone visit: No charge; Chat/online visit: No charge; Video visit: No charge. Deductible does not apply to copay	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)	X-ray: 20% coinsurance Lab: No charge	Not covered	Diagnostic lab services: Not subject to the deductible except when provided in the outpatient department of a hospital; 20% coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	None.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.kp.org/formulary	Generic drugs	Retail: $15 copay; Mail Order: $30 copay.	Not covered	Subject to formulary guidelines. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. Charges for second fill and maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: 30% copay; Mail Order: $60 copay.	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None.
	Physician/surgeon fees	20% coinsurance	Not covered	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance up to $500; deductible does not apply to copay	20% coinsurance up to $500; deductible does not apply to copay	None.
	Urgent care	$35 copay per visit; 20% coinsurance for covered services received during a visit; deductible does not apply to copay	$35 copay per visit; 20% coinsurance for covered services received during a visit; deductible does not apply to copay	Non-Plan Providers: only covered if you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None.
	Physician/surgeon fees	20% coinsurance	Not covered	None.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit; 20% coinsurance for covered services received during a visit; Phone visit: No charge; Chat/online visit: No charge; Video visit: No charge. Deductible does not apply to copay	Not covered	Group visit 50% of individual visit copay.
	Inpatient services	20% coinsurance	Not covered	None.
If you are pregnant	Office visits	20% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Limited to less than 8 hours per day and 28 hours per week.
	Rehabilitation services	Inpatient services: 20% coinsurance Outpatient services: $25 copay per visit; deductible does not apply to copay	Not covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient: Outpatient visits limited to 20 visits per therapy per year (Rehabilitation services for autism spectrum disorders are not subject to the visit limit.)
	Habilitation services	$25 copay per visit; deductible does not apply to copay	Not covered	Outpatient visits limited to 20 visits per therapy per year (Habilitation services for autism spectrum disorders are not subject to the visit limit.)
	Skilled nursing care	20% coinsurance	Not covered	Limited to 100 days per year.
	Durable medical equipment	20% coinsurance; deductible does not apply to copay	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 20% coinsurance.
	Hospice services	No charge	Not covered	Not subject to deductible.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If your child needs dental or eye care	Kaiser: Children's eye exam	$25 copay per visit; 20% coinsurance for covered services received during a visit.	Not covered	For services with an Ophthalmologist see "Specialist visit." Copay not subject to deductible.
	Plan: Children's eye exam	No charge	No charge	None.
	Plan: Children's glasses	All charges in excess of two-calendar year limit	All charges in excess of two-calendar year limit	Coverage limited to following two calendar year limits: $240 (single), $260 (bifocal), $290 (trifocal) for frames and lenses.
	Plan: Children's dental check-up	No charge; dental deductible does not apply	20% coinsurance; dental deductible does not apply	Coverage limited to 2 visits/12 month period.

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
- Infertility treatment
- Long-term Care/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- 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
- Chiropractic care (15 visits/year maximum)
- Dental care (Adult); $1,500/year
- Hearing aids with limits
- Private Duty Nursing
- Routine eye care (Adult), up to two-calendar year limit, including exam

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: Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. You may also contact your state insurance department. 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 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: the Plan at 1-800-527-1647, Kaiser Permanente at 1-855-249-5005 or TTY 711 or www.kp.org/memberservices, or Department of Labor's Employee

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

Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste. 850, Denver, CO 80202 or call: 303-894-7490. (Instate, toll free: 800-930-3745), or e-mail: insurance@dora.state.co.us.

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 1-855-249-5005.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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	$500
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	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$500
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	$300
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

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

The plan's overall deductible	$500
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	$500
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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