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 1-866-213-3062 (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 http://www.healthcare.gov/sbc-glossary or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750 Individual / $1,500 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. Preventive care and services indicated in chart starting on page 2.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,000 Individual / $4,000 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?	Some copayments, premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	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 1-866-213-3062 (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.
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	$25 / visit; deductible does not apply	Not covered	None
	Specialist visit	$40 / 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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$10 KP Pharmacy and SCL Health Colorado Front Range; $20 mail order / prescription: deductible does not apply	Not covered	Up to a 30-day supply for KP Pharmacy or 90-day supply mail order. Subject to formulary guidelines. *SCL Health Colorado Front Range pharmacies: Good Samaritan Medical Center and St. Joseph's Hospital
	Preferred brand drugs	$50 KP Pharmacy and SCL Health Colorado Front Range; $100 mail order / prescription: deductible does not apply	Not covered	
	Non-preferred brand drugs	50% up to $125 KP Pharmacy and SCL Health Colorado Front Range; 50% up to $250 mail order / prescription: deductible does not apply	Not covered	Non-preferred brand drugs available through formulary exception
	Specialty drugs	25% coinsurance up to $250 / prescription; deductible does not apply	Not covered	Up to a 30-day supply for self-administered injectables and oral drugs dispensed by Franklin Pharmacy at St. Joseph's Hospital

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance at SCL Health Colorado Front Range facility or KP Ambulatory Surgery Center; 30% coinsurance for any other Outpatient facility	Not covered	SCL Health Colorado Front Range: - Good Samaritan Medical Center - Saint Joseph Hospital - Lutheran Medical Center - Children's Hospital of Colorado
	Physician/surgeon fees	15% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$150 / visit + 15% coinsurance; deductible does not apply	$150 / visit + 15% coinsurance; deductible does not apply	Copayment waived if admitted as an inpatient
	Emergency medical transportation	15% coinsurance	15% coinsurance	None
	Urgent care	$50 / visit + 15% coinsurance; deductible does not apply	$50 / visit + 15% coinsurance; deductible does not apply	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance at SCL Health Colorado Front Range; 40% coinsurance for any other plan hospital	Not covered	SCL Health Colorado Front Range: - Good Samaritan Medical Center - Saint Joseph Hospital - Lutheran Medical Center - Children's Hospital of Colorado
	Physician/surgeon fees	15% coinsurance		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / individual visit; deductible does not apply	Not covered	$12 group visit; deductible does not apply
	Inpatient services	15% coinsurance deductible does not apply	Not covered	None
If you are pregnant	Office visits	No charge; deductible does not apply	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional	15% coinsurance	Not covered	SCL Health Colorado Front Range:

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)	
	services			- Good Samaritan Medical Center - Saint Joseph Hospital - Lutheran Medical Center - Children's Hospital of Colorado
	Childbirth/delivery facility services	15% coinsurance at SCL Health Colorado Front Range; 40% coinsurance for any other plan hospital		
If you need help recovering or have other special health needs	Home health care	15% coinsurance	Not covered	100 visits per calendar year
	Rehabilitation services	$40 / visit; deductible does not apply	Not covered	None
	Habilitation services	$40 / visit; deductible does not apply	Not covered	None
	Skilled nursing care	15% coinsurance	Not covered	100 days per calendar year
	Durable medical equipment	15% coinsurance	Not covered	None
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	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.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine eye care (Adult & Child)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 visit limit / year)
- Bariatric surgery
- Chiropractic care (20 visit limit / year)
- Hearing aids ($3,000 limit every 36 months)

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 shown in the chart below. 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 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-788-0710 (TTY: 711)
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.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 1-866-213-3062 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-213-3062 (TTY: 711)

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-213-3062 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-213-3062 (TTY: 711)

Your health benefits will be self-insured by your Plan Sponsor. Kaiser Permanente Insurance Company will provide certain administrative services for the Plan will not be an insurer of the Plan or financially liable for health care benefits under the Plan.

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	$750
Specialist Copayments	$40
Hospital (facility) Coinsurance	15%
Other Coinsurance	15%

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	**$12,731**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$750
Specialist Copayments	$40
Hospital (facility) Coinsurance	15%
Other Coinsurance	15%

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	**$5,971**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$114
Copayments	$1,240
Coinsurance	$20
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,429**

Mia's Simple Fracture

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

The plan's overall deductible	$750
Specialist Copayments	$40
Hospital (facility) Coinsurance	15%
Other Coinsurance	15%

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	**$1,925**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$698
Copayments	$280
Coinsurance	$123
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,101**

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