



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](http://www.kp.org/plandocuments) or call 1-800-813-2000 (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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-813-2000 (TTY:711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0                                                                                                                                                              | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Not Applicable.                                                                                                                                                  | 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/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</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> ? | \$600 Individual / \$1,200 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> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.                              | 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. See <a href="http://choose.kp.org/oracle">choose.kp.org/oracle</a> or call 1-800-813-2000 (TTY:711) for a list of <a href="#">Participating Providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                          |                                                         | Participating Provider<br>(You will pay the least)                                            | Non-Participating Provider<br>(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        | \$10 / visit                                                                                  | Not covered                                           | \$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.                                                                    |
|                                                                                                                                                                                                          | <a href="#">Specialist</a> visit                        | \$20 / 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 needed 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)     | X-ray: No charge<br>Lab tests: No charge                                                      | Not covered                                           | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                          | Imaging (CT/PET scans, MRIs)                            | No charge                                                                                     | Not covered                                           | Some services may require prior authorization.                                                                                                                                                                              |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> | Generic drugs                                           | \$5 (retail); \$10 (mail order) / <a href="#">prescription</a>                                | Not covered                                           | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.                                                                                                        |
|                                                                                                                                                                                                          | Preferred brand drugs                                   | \$10 (retail); \$20 (mail order) / <a href="#">prescription</a>                               | Not covered                                           | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.                                                                                                        |
|                                                                                                                                                                                                          | Non-preferred brand drugs                               | \$10 (retail); \$20 (mail order) / <a href="#">prescription</a>                               | Not covered                                           | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines, when approved through the exception process.                                                           |
|                                                                                                                                                                                                          | <a href="#">Specialty drugs</a>                         | Applicable Generic, Preferred brand or Non-preferred brand <a href="#">cost shares</a> apply. | Not covered                                           | Up to a 30-day supply (retail). Subject to <a href="#">formulary</a> guidelines, when approved through the exception process.                                                                                               |
| If you have outpatient surgery                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center)          | \$20 / visit                                                                                  | Not covered                                           | Prior authorization required.                                                                                                                                                                                               |
|                                                                                                                                                                                                          | Physician/surgeon fees                                  | No charge                                                                                     | Not covered                                           | Physician/surgeon fees are included in the Facility fee.                                                                                                                                                                    |

| Common Medical Event                                                             | Services You May Need                            | What You Will Pay                                  |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                   |
|----------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                  | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                          |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>              | \$35 / visit                                       | \$35 / visit                                          | <a href="#">Copayment</a> waived if admitted directly to the hospital as an inpatient.                                                                                                                                                   |
|                                                                                  | <a href="#">Emergency medical transportation</a> | No charge                                          | No charge                                             | None                                                                                                                                                                                                                                     |
|                                                                                  | <a href="#">Urgent care</a>                      | \$10 / visit                                       | Not covered                                           | <a href="#">Non-Participating Providers</a> covered when temporarily outside the service area: \$10 / visit.                                                                                                                             |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)               | No charge                                          | Not covered                                           | Prior authorization required.                                                                                                                                                                                                            |
|                                                                                  | Physician/surgeon fees                           | No charge                                          | Not covered                                           | Prior authorization required.                                                                                                                                                                                                            |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | \$10 / visit                                       | Not covered                                           | \$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.                                                                                 |
|                                                                                  | Inpatient services                               | No charge                                          | Not covered                                           | Prior authorization required.                                                                                                                                                                                                            |
| <b>If you are pregnant</b>                                                       | Office visits                                    | No charge                                          | Not covered                                           | Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                                  | Childbirth/delivery professional services        | No charge                                          | Not covered                                           | None                                                                                                                                                                                                                                     |
|                                                                                  | Childbirth/delivery facility services            | No charge                                          | Not covered                                           | None                                                                                                                                                                                                                                     |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                                  |                                                       | Limitations, Exceptions, & Other Important Information                                                                 |
|-----------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                        |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No charge                                          | Not covered                                           | 130 visit limit / year. Prior authorization required.                                                                  |
|                                                                       | <a href="#">Rehabilitation services</a>   | Outpatient: \$20 / visit<br>Inpatient: No charge   | Not covered                                           | Outpatient: 20 visit limit / therapy / year. Prior authorization required.<br>Inpatient: Prior authorization required. |
|                                                                       | <a href="#">Habilitation services</a>     | \$20 / visit                                       | Not covered                                           | 20 visit limit / therapy / year. Prior authorization required.                                                         |
|                                                                       | <a href="#">Skilled nursing care</a>      | No charge                                          | Not covered                                           | 100-day limit / year. Prior authorization required.                                                                    |
|                                                                       | <a href="#">Durable medical equipment</a> | No charge                                          | Not covered                                           | Subject to <a href="#">formulary</a> guidelines. Prior authorization required.                                         |
|                                                                       | <a href="#">Hospice services</a>          | No charge                                          | Not covered                                           | Prior authorization required.                                                                                          |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | \$10 / visit for refractive exam.                  | 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 <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>Children's glasses</li> <li>Cosmetic surgery</li> <li>Dental care (Adult and child)</li> </ul>                                                             | <ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>                                         | <ul style="list-style-type: none"> <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>Acupuncture (20 visit limit / year)</li> <li>Bariatric surgery</li> </ul>                                                                                  | <ul style="list-style-type: none"> <li>Chiropractic care (20 visit limit / year)</li> <li>Hearing aids (Adults: \$2,000 limit / ear / 36 months; under age 26: 1 aid / ear / 36 months)</li> </ul> | <ul style="list-style-type: none"> <li>Infertility treatment (\$30,000 limit / lifetime)</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 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](http://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                                                            | 1-800-813-2000 (TTY:711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>      |
| Department of Labor's Employee Benefits Security Administration                              | 1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                         |
| Oregon Division of Financial Regulation                                                      | 1-888-877-4894 or <a href="http://www.dfr.oregon.gov">www.dfr.oregon.gov</a>                              |
| Washington Department of Insurance                                                           | 1-800-562-6900 or <a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a>                          |

**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 1-800-813-2000 (TTY: 711).

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-813-2000 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-813-2000 (TTY: 711).

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-800-813-2000 (TTY: 711) uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711).

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-813-2000 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-813-2000 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-813-2000 (TTY: 711).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$20 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$0  |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$0  |

### 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 copayment</a>                          | \$20 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$0  |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$0  |

### 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 copayment</a>                          | \$20 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$0  |
| ■ Other (x-ray) <a href="#">copayment</a>                       | \$0  |

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*

|                             |      |
|-----------------------------|------|
| <a href="#">Deductibles</a> | \$0  |
| <a href="#">Copayments</a>  | \$10 |
| <a href="#">Coinsurance</a> | \$0  |

*What isn't covered*

|                      |      |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

|                            |      |
|----------------------------|------|
| The total Peg would pay is | \$70 |
|----------------------------|------|

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*

|                             |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$0   |
| <a href="#">Copayments</a>  | \$300 |
| <a href="#">Coinsurance</a> | \$0   |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                            |       |
|----------------------------|-------|
| The total Joe would pay is | \$300 |
|----------------------------|-------|

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*

|                             |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$0   |
| <a href="#">Copayments</a>  | \$100 |
| <a href="#">Coinsurance</a> | \$0   |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                            |       |
|----------------------------|-------|
| The total Mia would pay is | \$100 |
|----------------------------|-------|

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