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, call 1-855-249-5018. 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.cciio.cms.gov or call 1-855-249-5018 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
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?	In-network: Medical: $1,100/individual; $3,600/family. Prescription Drug: $5,500/individual; $9,600/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 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 1-855-249-5018 for a list of 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 full cost if you use an out-of-network provider. 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.	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.

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	$5 copay/visit.	Not covered.	None.
	Specialist visit	$5 copay/visit.	Not covered.	You may need a referral to see a specialist.
	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	Not covered.	None.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carefirst.com/rxgroup	Generic drugs	Retail: $15 copay/ prescription. Mail order: $20 copay/ prescription.	Not covered.	Limit: Retail 31-day supply; Mail order: 90-day supply. No charge for ACA-required generic preventive drugs (e.g., FDA-approved generic contraceptives) or brand name preventive drugs if a generic is not medically appropriate. Preauthorization may be required for certain drugs or coverage may be denied.
	Preferred brand drugs	Retail:$30 copay/ prescription. Mail order: $40 copay/ prescription.	Not covered.	
	Non-preferred brand drugs	Retail:$40 copay/ prescription. Mail order: $60 copay/ prescription.	Not covered.	
	Specialty drugs	See above copays.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$5 copay/surgery.	Not covered.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$50 copay/visit.	$50 copay/visit.	Copay waived if admitted.
	Emergency medical transportation	No charge.	Not covered.	None.
	Urgent care	$5 copay/visit.	$5 copay/visit.	Out-of-network providers are covered outside the service area only.

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 a hospital stay	Facility fee (e.g., hospital room)	No charge.	Not covered.	None.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/visit.	Not covered.	Psychological and neuropsychological testing for ability, aptitude, intelligence, or interest not covered.
	Inpatient services	No charge.	Not covered.	
If you are pregnant	Office visits	First visit: $5 copay; Thereafter: no charge.	Not covered.	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge.	Not covered.	
	Childbirth/delivery facility services	No charge.	Not covered.	
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Limit: 2 hours/visit and 3 visits/day.
	Rehabilitation services	Inpatient: No charge. Outpatient: $5 copay/visit.	Not covered.	Physical therapy limit: 30 visits per year per course of treatment. Speech and occupational therapy limit: 90 consecutive days per year per course of treatment.
	Habilitation services	Inpatient: No charge. Outpatient: $5 copay/visit.	Not covered.	Covered only for individuals under age 19.
	Skilled nursing care	No charge.	Not covered.	Limit: 100 days/year.
	Durable medical equipment	No charge.	Not covered.	None.
	Hospice services	No charge.	Not covered.	None.
If your child needs dental or eye care	Children's eye exam	$5 copay/visit.	You pay 100% and apply for reimbursement up to $38.	Separately administered by National Vision Administrators. Limit: 1 exam/year.
	Children's glasses	$15 copay/pair lenses; no charge up to $75/frames.	You pay 100% and apply for reimbursement up to $41.50/pair lenses and $29.50/frames.	Separately administered by National Vision Administrators. Limit: 1 pair glasses/year.
	Children's dental check-up	PPO: no charge. HMO: $5 copay/exam.	PPO: no charge. HMO: not covered.	Separately administered by United Concordia. PPO: limit 2 exams/year.

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 (except for services related to mastectomy, cleft lip, or cleft palate).
- Long-term care.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing.
- Routine foot care.

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

- Acupuncture (limit: 20 visits per calendar year).
- Bariatric surgery.
- Chiropractic care (limit: 20 visits per calendar year).
- Dental care (Adult).
- Hearing aids (limit: 1 hearing aid and $1,400 per ear every 36 months; no coverage for individuals 19 and older).
- Infertility treatment (IVF: 3 attempts/live birth; lifetime max of $100,000).
- Routine eye care (Adult).
- Weight loss programs.

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: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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, call 1-855-249-5018.

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 1-855-249-5018.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5018.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-249-5018.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-249-5018.

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	$0
Specialist copay	$5
Hospital (facility) cost sharing	$0
Other cost sharing	$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	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$30

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

The plan's overall deductible	$0
Specialist copay	$5
Hospital (facility) cost sharing	$0
Prescription drugs copay	$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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$540
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$540

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

The plan's overall deductible	$0
Specialist copay	$5
Emergency room copay	$50
Other cost sharing	$0

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	$0
Copayments	$280
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$280

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