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.

his 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 -855-249-5018 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or ther underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary or call 1-855-249-5018 (TTY: 711) to request a copy.

nportant Questions	Answers	Why this Matters:
Vhat is the overall eductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
re there services overed before you meet our deductible?	Not Applicable.	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/.
re there other eductibles for specific ervices?	No.	You don't have to meet deductibles for specific services.
Vhat is the out-of-pocket mit for this plan?	$3,500 Individual / $9,400 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.
Vhat is not included in he out-of-pocket limit?	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.
Vill you pay less if you se a network provider?	Yes. See www.kp.org or call 1-855-249-5018 (TTY: 711) for a list of network providers.	This ___

All

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org.	Generic drugs	$10 / prescription at Plan Pharmacy; $20 / prescription at Participating Pharmacy; $8 / prescription through Mail Order	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2 copays through Mail Order. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Preferred brand drugs	$20 / prescription at Plan Pharmacy; $40 / prescription at Participating Pharmacy; $18 / prescription through Mail Order	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2 copays through Mail Order. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Non-preferred brand drugs	$35 / prescription at Plan Pharmacy; $55 / prescription at Participating Pharmacy; $33 / prescription through Mail Order	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2 copays through Mail Order. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Specialty drugs	Applicable Generic, Preferred, and Non-Preferred copayments	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2 copays through Mail Order. No charge for oral chemotherapy drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 / visit	Not covered	None
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	$50 / visit	$50 / visit	Waived if admitted as inpatient
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$20 / visit	$20 / visit	

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If your child needs dental or eye care	Children's eye exam	$10 / Optometrist visit; $20 / Ophthalmologist visit	Not covered	None
	Children's glasses	No charge	Not covered	1 pair of glasses / year limited to single or bifocal lenses or 1st purchase of contact lenses / year or 2 pair / eye / year

District of Columbia Department of Insurance	1-877-685-6391 or www.disb.dc.gov/

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from

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 copayment	$20
Hospital (facility) copayment	$100
Other (blood work) copayment	$0

This EXAMPLE event includes services like:
Specialist office visits (S U H Q D)W D O F D U H
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (X O W U D V R X Q G)V D Q G E O R R G Z R U N
Specialist visit (D Q H V)W K H V L D

Total Example Cost	$12,800
In this example, Peg would pay:	
& R V W 6 K D U L Q J	
Deductibles	$0
Copays	$100
Coinsurance	$0
: K D W L V Q W F R Y H U H G	
Limits or exclusions	$60
The total Peg would pay is	$160

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