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, review the Intel Pay Stock and Benefits Handbook (the official plan document) Chapter 6, call The Intel Health Benefits center at 1-877-466-9236, or see www.my.kp.org/connectedcare or call 1-844-533-2885 or 1-800-735-2900 (TTY). 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?	In-network Provider: None Out-of-Network Provider: $250 Individual / $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?	**Yes. $1,500** Individual / **$3,000** 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?	Premiums, balance-billing charges and 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.my.kp.org/connectedcare or call 1-844-533-2885 or 1-800-735-2900 (TTY) 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?	**No**.	This plan will pay some or all of the costs to see a specialist for covered services

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	$10 / visit, deductible does not apply	40% coinsurance	None
	Specialist visit	$25 / visit, deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	40% coinsurance	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, deductible does not apply	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge, deductible does not apply	40% coinsurance	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 retail; $20 mail order / prescription, deductible does not apply	$10 retail*	**At KP Pharmacy**: Up to a 30-day supply retail; 31-90-day supply mail order. No charge for contraceptives, subject to formulary guidelines. Infertility drugs are covered. Mail order delivery outside OR and WA through Optum network. **At Out-of-network pharmacy**: Up to 30 day supply retail. Mail order is not available. Non-Participating pharmacy coverage is through Optum contracted pharmacies. * Member pays the amount above allowable cost plus the applicable copay as listed
	Preferred brand drugs	$20 retail; $50 mail order / prescription, deductible does not apply	$20 retail*	
	Non-preferred brand drugs	$35 retail; $90 mail order / prescription after drug deductible	$35 retail*	
	Specialty drugs	Follows the Generic/Brand/Non-preferred cost share	Follows the Generic/Brand/Non-preferred cost share	

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)	$100 / procedure, deductible does not apply	40% coinsurance	None
	Physician/surgeon fees	Included in facility fee	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 / visit, deductible does not apply		Copayment waived if admitted as inpatient
	Emergency medical transportation	No charge, deductible does not apply		None
	Urgent care	$50 / visit, deductible does not apply	40% coinsurance	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission, deductible does not apply	40% coinsurance	None
	Physician/surgeon fees	Included in facility fee	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 / visit, deductible does not apply	40% coinsurance	None
	Inpatient services	$250 / admission, deductible does not apply	40% coinsurance	None
If you are pregnant	Office visits	No charge, deductible does not apply	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) 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 services	Included in facility fee	40% coinsurance	None
	Childbirth/delivery facility services	$250 / admission, deductible does not apply	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge, deductible does not apply	40% coinsurance	None
	Rehabilitation services	$10 / visit, deductible does not apply	40% coinsurance	60 visits / calendar year shared between In and Out-of-network

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)	
	Habilitation services	$10 / visit, deductible does not apply	40% coinsurance	60 visits / calendar year shared between In and Out-of-network
	Skilled nursing care	$250 / admission, deductible does not apply	40% coinsurance	100 days / calendar year out-of-network
	Durable medical equipment	No charge, deductible does not apply	40% coinsurance	None
	Hospice services	No charge, deductible does not apply	40% coinsurance	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)
- Long-term care
- Routine eye care (Adult & Child)
- 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.)

- Acupuncture (30 visit limit / year
- Bariatric surgery
- Chiropractic care (30 visit limit / year)
- Hearing aids
- Infertility treatment ($40,000 limit / lifetime)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 California Department of Managed Health Care and Department of Insurance at 980 9th St, Suite #500 Sacramento, CA 95814, 1-888-466-2219 or http://www.HealthHelp.ca.gov:

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

Kaiser Permanente Member Services	1-844-533-2885 or 1-800-735-2900 (TTY) or www.my.kp.org/connectedcare
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 1-800-788-0616 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-788-0616 (TTY: 711)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-788-0616 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-788-0616 (TTY: 711)].

Connected Care Kaiser Copay benefits are self-insured by your Plan sponsor. Kaiser Permanente Insurance Company provides certain administrative services for this Plan option and 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	$0
Specialist Copayments	$25
Hospital (facility) Copayments	$250
Other Copayments	$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	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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 Copayments	$25
Hospital (facility) Copayments	$250
Other Copayments	$0

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	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$420**

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

The plan's overall deductible	$0
Specialist Copayments	$25
Hospital (facility) Copayments	$250
Other Copayments	$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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

For more information about limitations and exceptions, see the plan or policy document: The Intel Pay Stock and Benefits Handbook (the official plan documents.)