




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?	\$1,500 Individual \$3,000 Individual plus Children \$3,750 Individual plus Spouse	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 policy, the overall family deductible must be met before the plan begins to pay.
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?	\$2,100 Individual \$4,200 Individual plus Children \$5,000 Individual plus Spouse	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 , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums , balance-billing 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.
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	5% coinsurance	40% coinsurance	None
	Specialist visit	5% coinsurance	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)	5% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	5% coinsurance	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	5% coinsurance	40% coinsurance	At KP Pharmacy: Up to a 90-day supply. 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 90-day supply retail. Mail order is not available. Non-Participating pharmacy coverage is through Optum contracted pharmacies
	Preferred brand drugs	5% coinsurance	40% coinsurance	
	Non-preferred brand drugs	5% coinsurance	40% coinsurance	
	Specialty drugs	5% coinsurance	40% coinsurance	Preventive Tier \$0 for up to 90-day supply, not subject to Deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	40% coinsurance	None
	Physician/surgeon fees	5% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	5% coinsurance	5% coinsurance	None
	Emergency medical transportation	5% coinsurance	5% coinsurance	None

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

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)	
	Urgent care	5% coinsurance	40% coinsurance	Non-Plan <u>providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	40% coinsurance	None
	Physician/surgeon fees	5% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	5% coinsurance	40% coinsurance	None
	Inpatient services	5% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	No charge, <u>deductible</u> does not apply	40% coinsurance	Cost sharing does not apply for <u>preventive</u> services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Depending on the type of services, a <u>copayment, coinsurance, or deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	5% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	5% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	5% coinsurance	40% coinsurance	None
	Rehabilitation services	5% coinsurance	40% coinsurance	None
	Habilitation services	5% coinsurance	40% coinsurance	None
	Skilled nursing care	5% coinsurance	40% coinsurance	100 days / calendar year out-of-network
	Durable medical equipment	5% coinsurance	40% coinsurance	None
	Hospice services	No charge, <u>deductible</u> 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, kwijigo holne' 1-800-788-0616 (TTY: 711)].

Connected Care Kaiser HDHP 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](#) \$1,500
- [Specialist Coinsurance](#) 5%
- Hospital (facility) [Coinsurance](#) 5%
- Other [Coinsurance](#) 5%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$512
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,072

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist Coinsurance](#) 5%
- Hospital (facility) [Coinsurance](#) 5%
- Other [Coinsurance](#) 5%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$359
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$1,915

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist Coinsurance](#) 5%
- Hospital (facility) [Coinsurance](#) 5%
- Other [Coinsurance](#) 5%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$94
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,594

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