

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling 1-800-278-3296.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See chart on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$1,500 Individual/\$3,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, health care this plan doesn't cover, and cost sharing for certain services listed in plan documents.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of plan providers , see www.kp.org or call 1-800-278-3296.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-278-3296 or 711 (TTY), or visit us at www.kp.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the

Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-800-278-3296 or 711 (TTY) to request a copy.

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 per visit	Not Covered	—————none—————
	Specialist visit	\$20 per visit	Not Covered	Services related to infertility covered at \$20 per visit.
	Other practitioner office visit	\$20 per visit for acupuncture services.	Not Covered	Chiropractic care not covered. Physician referred acupuncture.
	Preventive care/ screening/ immunization	No Charge	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: \$10 per encounter; Lab tests: \$10 per encounter	Not Covered	—————none—————
	Imaging (CT/PET scans, MRI's)	\$10 per procedure	Not Covered	—————none—————

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
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	Plan pharmacy: \$10 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines, certain drugs may be covered at a different cost share
	Preferred brand drugs	Plan pharmacy: \$20 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines, certain drugs may be covered at a different cost share
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	20% coinsurance up to \$150 per prescription for 1 to 30 days	Not Covered	In accordance with formulary guidelines, certain drugs may be covered at a different cost share
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$20 per procedure	Not Covered	---none---
	Physician/surgeon fees	No Charge	Not Covered	---none---
If you need immediate medical attention	Emergency room services	\$100 per visit	\$100 per visit	---none---
	Emergency medical transportation	\$100 per trip	\$100 per trip	---none---
	Urgent care	\$20 per visit	\$20 per visit	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	---none---
	Physician/surgeon fee	No Charge	Not Covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 per individual visit; \$10 per group visit; No Charge for other outpatient services	Not Covered	---none---
	Mental/Behavioral health inpatient services	No Charge	Not Covered	---none---
	Substance use disorder outpatient services	\$20 per individual visit; \$5 per group visit; \$5 per visit for other outpatient services	Not Covered	---none---
	Substance use disorder inpatient services	No Charge	Not Covered	---none---
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge; Postnatal care: No Charge	Not Covered	Prenatal: Cost sharing is for routine preventive care only. Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	---none---
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum per visit, Up to 3 visits maximum per day, Up to 100 visits maximum per year.
	Rehabilitation services	Inpatient: No Charge; Outpatient: \$20 per visit	Not Covered	---none---
	Habilitation services	\$20 per visit	Not Covered	---none---
	Skilled nursing care	No Charge	Not Covered	Up to a 100 day maximum per benefit period
	Durable medical equipment	No Charge	Not Covered	Must be accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Limited to a diagnosis of terminal illness with a life expectancy of twelve months or less.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	---none---
	Glasses	Amount in excess of a \$175 allowance	Not Covered	Allowance limited to once every 24 months. You may have other vision coverage not described here. Refer to "Other Covered Services" for additional information.
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Chiropractic care Cosmetic Surgery Dental care (may be available under a separate dental plan) 	<ul style="list-style-type: none"> Hearing aids Long-term care Non-emergency care when traveling outside the US 	<ul style="list-style-type: none"> Private-duty nursing Routine foot care unless medically necessary Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> Acupuncture (plan provider referred) Bariatric surgery 	<ul style="list-style-type: none"> Infertility treatment 	<ul style="list-style-type: none"> Routine eye care (Adult) and eyewear allowance (Adult) (additional coverage may be available under separate vision plan)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-278-3296. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Kaiser Permanente at 1-800-278-3296 or online at www.kp.org/memberservices.

If this coverage is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

If this coverage is not subject to ERISA, you may also contact the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

Additionally, this consumer assistance program can help you file your appeal:
Department of Managed Health Care Help Center 1-888-466-2219
980 9th Street, Suite 500 <http://www.healthhelp.ca.gov>
Sacramento, CA 95814 helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0616, TTY/TDD 711

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296, TTY/TDD 711

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585, TTY/TDD 711

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296, TTY/TDD 711

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,270
- Patient pays \$270

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$70
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$270

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,520
- Patient pays \$880

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$800
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$880

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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