**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** or by calling **1-800-278-3296**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,500** Individual/**$3,000** Family (See chart starting on page 2 for when deductible is waived.) | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **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 out–of–pocket limit on my expenses?** | **Yes**. **$3,000** Individual/**$6,000** 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 out–of–pocket limit?** | Premiums, health care this plan doesn't cover. | 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 *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | **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 specialist?** | **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**. |

- **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 Plan Provider | Your cost if you use a Non-Plan Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 10% coinsurance per visit | Not Covered | After deductible. |
| | Specialist visit | 10% coinsurance per visit | Not Covered | After deductible. |
| | Other practitioner office visit | 10% coinsurance per visit for acupuncture services. | Not Covered | After deductible. Chiropractic care not covered. Physician referred acupuncture. |
| | Preventive care/ screening/ immunization | No Charge | Not Covered | Deductible waived. 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% coinsurance per encounter; Lab tests: 10% coinsurance per encounter | Not Covered | After deductible. |
| | Imaging (CT/PET scans, MRI's) | 10% coinsurance per procedure | Not Covered | After deductible. |

| Common Medical Event | Services You May Need | Your cost if you use a Plan Provider | Your cost if you use a Non-Plan Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>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 | After overall deductible. In accordance with formulary guidelines. Certain drugs may be covered at a different cost share. |
| | Preferred brand drugs | Plan pharmacy: $30 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 | After overall deductible. 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 | Same as preferred brand drugs. | Not Covered | Same as preferred brand drugs when approved through exception process. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance per procedure | Not Covered | After deductible. |
| | Physician/surgeon fees | 10% coinsurance per procedure | Not Covered | After deductible. |
| **If you need immediate medical attention** | Emergency room services | 10% coinsurance per visit | 10% coinsurance per visit | After deductible. |
| | Emergency medical transportation | 10% coinsurance per trip | 10% coinsurance per trip | After deductible. |
| | Urgent care | 10% coinsurance per visit | 10% coinsurance per visit | After deductible. Non-Plan providers covered when outside the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance per admission | Not Covered | After deductible. |
| | Physician/surgeon fee | 10% coinsurance per admission | Not Covered | After deductible. |

| Common Medical Event | Services You May Need | Your cost if you use a Plan Provider | Your cost if you use a Non-Plan Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 10% coinsurance per individual visit; 10% coinsurance per group visit | Not Covered | After deductible. |
| | Mental/Behavioral health inpatient services | 10% coinsurance per admission | Not Covered | After deductible. |
| | Substance use disorder outpatient services | 10% coinsurance per individual visit; 10% coinsurance per group visit | Not Covered | After deductible. |
| | Substance use disorder inpatient services | 10% coinsurance per admission | Not Covered | After deductible. |
| **If you are pregnant** | Prenatal and postnatal care | Prenatal care: No Charge; Postnatal care: 10% coinsurance per visit | Prenatal care: Not covered; Postnatal care: Not covered | Prenatal: Deductible waived. Cost sharing is for routine preventive care only; Postnatal: After deductible. Cost sharing is for the first postnatal visit only. |
| | Delivery and all inpatient services | 10% coinsurance per admission | Not Covered | After deductible. |

| Common Medical Event | Services You May Need | Your cost if you use a Plan Provider | Your cost if you use a Non-Plan Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not Covered | After deductible. Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per calendar year. |
| | Rehabilitation services | Inpatient: 10% coinsurance per admission; Outpatient: 10% coinsurance per visit | Not Covered | After deductible. |
| | Habilitation services | 10% coinsurance per visit | Not Covered | After deductible. |
| | Skilled nursing care | 10% coinsurance per admission | Not Covered | After deductible. Up to 100 days maximum per benefit period. |
| | Durable medical equipment | 10% coinsurance per item | Not Covered | After deductible. Must be in accordance with formulary guidelines. Requires prior authorization. |
| | Hospice service | No Charge | Not Covered | After deductible. Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less. |
| **If your child needs dental or eye care** | Eye exam | 10% coinsurance per visit | Not Covered | After deductible. |
| | Glasses | Not Covered | Not Covered | ——————none—————— |
| | 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 excluded services.)**

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.) | | |
|---|---|---|
| • Acupuncture (plan provider referred) | • Bariatric surgery | • Routine eye care (Adult) |

## 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/heatlhreform, 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 | 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 or TTY/TDD 1-800-777-1370

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 or TTY/TDD 1-800-777-1370

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-757-7585 or TTY/TDD 1-800-777-1370

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 or TTY/TDD 1-800-777-1370

*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** $5,220
- **Patient pays** $2,320

**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 | $1,500 |
| Copays | $20 |
| Coinsurance | $600 |
| Limits or exclusions | $200 |
| **Total** | **$2,320** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,320
- **Patient pays** $2,080

**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 | $1,500 |
| Copays | $400 |
| Coinsurance | $100 |
| Limits or exclusions | $80 |
| **Total** | **$2,080** |

# 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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