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 kp.org or by calling 1-800-278-3296.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	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.
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?	For **preferred providers** **$6,350** person / **$12,700** 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, non-covered services, prescription drugs, and durable medical equipment	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 **preferred providers**, see healthy.kaiserpermanente.org/health/care/consumer/locate-our-services/doctors-and-locations **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. All services outside of primary care with the exception of obstetrics and gynecology, mental health, chemical dependency, and optometry require a referral.	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 **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay	Not Covered	——————none——————
	Specialist visit	$50 Copay	Not Covered	——————none——————
	Other practitioner office visit	$30 Copay	Not Covered	——————none——————
	Preventive care/screening/immunization	No Charge	Not Covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	$30 Copay	Not Covered	Lab: $30 Copay; X-Ray and Diagnostic Imaging: $50 Copay.
	Imaging (CT/PET scans, MRIs)	$250 Copay	Not Covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at kp.org/formulary.	Generic drugs	$19 Copay	Not Covered	$19 copay for up to a 30-day supply at a KP plan pharmacy or mail-order service. $38 copay for up to 100-day supply mail order. Female contraceptives are no charge.
	Preferred brand drugs	$50 Copay	Not Covered	$50 copay for up to a 30-day supply at a KP plan pharmacy or mail-order. $100 copay for up to 100-day supply mail order. Female contraceptives are no charge.
	Non-preferred brand drugs	$50 Copay	Not Covered	$50 copay for up to a 30-day supply at a KP plan pharmacy or mail-order services. $100 for up to 100-day supply mail order. Female contraceptives are no charge.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
	Specialty drugs	$50 Copay	Not Covered	$50 copay for up to a 30-day supply at a KP plan pharmacy or mail-order service. $100 copay for up to 100-day supply mail order. Female contraceptives are no charge.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$600 Copay	Not Covered	Copay is per procedure and includes the outpatient facility fee and the outpatient surgery physician and surgical service fee.
	Physician/surgeon fees	$600 Copay	Not Covered	Copay is per procedure and includes the outpatient facility fee and the outpatient surgery physician and surgical service fee.
If you need immediate medical attention	Emergency room services	$250 Copay	$250 Copay	Copay is waived if admitted to hospital as inpatient.
	Emergency medical transportation	$250 Copay	$250 Copay	Copay is per trip
	Urgent care	$30 Copay	$30 Copay	Urgent care from non-participating providers is covered if a reasonable person would believe that your health would seriously deteriorate if you delayed treatment.
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 Copay	Not Covered	Copay is per day up to 5 days and includes inpatient hospital services fee and inpatient physician and surgical services fee.
	Physician/surgeon fee	$600 Copay	Not Covered	Copay is per day up to 5 days and includes inpatient hospital services fee and inpatient physician and surgical services fee.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 Copay	Not Covered	Group visits are $15 copay per visit.
	Mental/Behavioral health inpatient services	$600 Copay	Not Covered	Copay is per day.
	Substance use disorder outpatient services	$30 Copay	Not Covered	Group visits are $15 copay per visit.
	Substance use disorder inpatient services	$600 Copay	Not Covered	Copay is per day.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Routine Prenatal Care: no charge. Postnatal Care: no charge first post partum visit.
	Delivery and all inpatient services	$600 Copay	Not Covered	Copay is per day up to 5 days
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 100 visits per calendar year
	Rehabilitation services	Inpatient:$600 Copay Outpatient:$30 Copay	Not Covered	Inpatient:Copay is per day up to 5 days Outpatient:None
	Habilitation services	$30 Copay	Not Covered	——————none——————
	Skilled nursing care	$300 Copay	Not Covered	Copay is per day up to 5 days. Coverage is for 100 days per benefit period.
	Durable medical equipment	20% Coinsurance	Not Covered	Most items are not covered. See the durable medical formulary guidelines for details.
	Hospice service	No Charge	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	——————none——————
	Glasses	No Charge	Not Covered	Coverage is limited to one pair of glasses per year with selection from collection frames.
	Dental check-up	No Charge	Not Covered	Limited to two check-ups per year. Covered by Delta Dental.

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 • Hearing Aids • Infertility Treatment	• Long-Term/Custodial Nursing Home Care • Non-Emergency Care when Travelling Outside the U.S. • Private-Duty Nursing	• Routine Dental Services (Adult) • Routine Eye Exam (Adult) • 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 • Bariatric Surgery	• Routine Foot Care with limits	• Routine Hearing Tests

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-278-3296. You may also contact your state insurance department at 1-888-466-2219.

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: 1-800-278-3296. You may also contact your state consumer assistance program at 1-888-466-2219.

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 <u>does provide</u> minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-278-3296 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: 若有問題：請撥打1-800-278-3296 或 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** $6,540
- **Patient pays** $1,000

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
Co-pays	$ 800
Co-insurance	$ 0
Limits or exclusions	$ 200
Total	**$1,000**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

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
Co-pays	$1,200
Co-insurance	$ 200
Limits or exclusions	$ 80
Total	**$1,480**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.