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?	**$1,000** Individual/**$2,000** Family	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** **$3,500** Individual/**$7,000** 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, prescription drug copayments, durable medical equipment cost sharing, and payments for 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 preferred 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**	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 6. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-278-3296, TTY/TDD 1-800-777-1370 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 www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf, or call 1-800-278-3296 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	$30 copayment/visit	Not covered	Not subject to deductible
	Specialist visit	$30 copayment/visit	Not covered	Not subject to deductible
	Other practitioner office visit	$30 copayment/visit for acupuncture	Not covered	Not subject to deductible. Chiropractic care not covered. Physician referred acupuncture only.
	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)	$10 copayment/encounter	Not covered	After deductible
	Imaging (CT/PET scans, MRIs)	$50 copayment/procedure	Not covered	After deductible

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	$10 copayment/ prescription for up to 30-day supply	Not covered	Not subject to deductible. $20 copayment/prescription for 31- to 60-day supply, $30 for a 61- to 100-day supply. Mail order incentive: $10 for up to a 30-day supply, $20 for a 31- to 100-day supply. In accordance with formulary guidelines. Certain drugs may be covered at a higher cost share
	Preferred brand drugs	$30 copayment/ prescription for up to 30-day supply	Not covered	Not subject to deductible. $60 copayment/prescription for 31- to 60-day supply, $90 for a 61- to 100-day supply. Mail order incentive: $30 for up to a 30-day supply, $60 for a 31- to 100-day supply. In accordance with formulary guidelines. Certain drugs may be covered at a higher cost share.
	Non-preferred brand drugs	$30 copayment/ prescription for up to 30-day supply	Not covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copayment/ procedure	Not covered	After deductible
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$100 copayment/visit		After deductible
	Emergency medical transportation	$75 copayment/trip		After deductible
	Urgent care	$30 copayment/visit		Not subject to deductible. Urgent care from non-participating providers is covered if a reasonable person would believe that your health would seriously deteriorate if you delayed treatment.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment/day	Not covered	After deductible
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 individual copayment/visit $15 group copayment/visit	Not covered	Not subject to deductible
	Mental/Behavioral health inpatient services	$500 copayment/day	Not covered	After deductible
	Substance use disorder outpatient services	$30 individual copayment/visit $5 group copayment/visit	Not covered	Not subject to deductible
	Substance use disorder inpatient services	$500 copayment/day	Not covered	After deductible
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Prenatal: Not subject to deductible. Cost sharing for prenatal care is for routine preventive care only. Postnatal: After deductible. Cost sharing for postnatal care is for the first postnatal visit only.
	Delivery and all inpatient services	$500 copayment/day	Not covered	After deductible

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Not subject to deductible. Up to 100 2-hour visits per calendar year.
	Rehabilitation services	$30 copayment/day	Not covered	After deductible
	Habilitation services	$30 copayment/day	Not covered	After deductible. Limited to services to maintain/improve skills or functioning at risk due to medical deficits.
	Skilled nursing care	$50 copayment/day	Not covered	After deductible. Up to 60 days per benefit period.
	Durable medical equipment	30% coinsurance/item	Not covered	Not subject to deductible. Limited to base-covered items in accordance with KP DME formulary guidelines.
	Hospice service	No charge	Not covered	Not subject to deductible. Limited to a diagnosis of terminal illness with a life expectancy of twelve months or less.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Not subject to deductible
	Glasses	Not covered	Not covered	---none----
	Dental check-up	Not covered	Not covered	---none----

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
- 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)
- Routine foot care

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
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
www.healthhelp.ca.gov
helpline@dmhc.ca.gov

Language Access Services:

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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296

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** $5,870
- **Patient pays** $1,670

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	$1,000
Copays	$520
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,670**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,410
- **Patient pays** $1,990

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	$1,000
Copays	$600
Coinsurance	$310
Limits or exclusions	$80
Total	**$1,990**

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.