Kaiser Permanente: $40/$1000 PPO Plan Insurance

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: [redacted] - [redacted]

Coverage for: Individual + Family | **Plan Type:** PPO

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/kpic/ppo or by calling 1-800-788-0710.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating Provider/Nonparticipating Provider: $1,000 person/$2,000 family, combined deductible.	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?	Yes. $200 deductible for MedImpact pharmacy Brand-name drug prescription, $100 deductible for Emergency room services and $50 combined deductible for Home health care. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. Participating Provider: $5,000 person/$10,000 family; Nonparticipating Provider: $10,000 person/$20,000 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, precertification penalties, balance-billed charges and 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. See www.kp.org/kpic/ppo or visit www.multiplan.com/kaiser for a list of participating network providers.	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?	No.	You can see the specialist you choose without permission from this plan.
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 participating 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
		Participating Provider	Nonparticipating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	50% coinsurance/visit after deductible	Participating Provider: Deductible does not apply.
	Specialist visit	$40 copay/visit	50% coinsurance/visit after deductible	Participating Provider: Deductible does not apply.
	Other practitioner office visit	Not Covered	Not Covered	——————none——————
	Preventive care/ screening/immunization	No Charge	50% coinsurance/visit	Deductible does not apply. Some preventive screenings (such as lab and imaging) may be at a different cost share. Participating Provider: Routine Physical Exams are limited to one exam per calendar year. Nonparticipating Provider: Routine Physical exams are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance/ encounter after deductible	50% coinsurance/ encounter after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	30% coinsurance/ procedure after deductible	50% coinsurance/ procedure after deductible	Precertification required. Failure to precertify may result in a penalty up to $500.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/kpic/ppo	Generic drugs	$15 copay/prescription	$15 copay/prescription	Prescriptions covered only when obtained from MedImpact Network Pharmacies. Covers up to a 30 day supply (retail Pharmacy; 31-100 day supply (mail order prescription). Mail Order is available at 2 times the retail copay for up to a 100-day supply through Walgreen's Mail Service. Prescription Drugs do not apply to Medical Plan Deductible. Self-Injectable Drugs are not available through Mail Order. Insulin is covered at the Brand or Generic copay amounts.
	Brand drugs	$35 copay/prescription after $200 brand name drug deductible	$35 copay/prescription after $200 brand name drug deductible	
	Contraceptive Drugs	No Charge	No Charge	
	Self-Injectable Drugs	30% coinsurance/ prescription	30% coinsurance/ prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance/surgical encounter after deductible	50% coinsurance/surgical encounter after deductible	Precertification required. Failure to precertify may result in a penalty up to $500. Nonparticipating Provider: Outpatient surgery facility fees are limited to a maximum benefit of $400 per surgical encounter.
	Physician/surgeon fees	30% coinsurance/surgical encounter after deductible	50% coinsurance/surgical encounter after deductible	
If you need immediate medical attention	Emergency room services	$100 deductible, then 30% coinsurance/visit after deductible	$100 deductible, then 30% coinsurance/visit after deductible	——————none——————
	Emergency medical transportation	50% coinsurance/trip after deductible	50% coinsurance/trip after deductible	——————none——————
	Urgent care	30% coinsurance/visit after deductible	50% coinsurance/visit after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance/ admission after deductible	50% coinsurance/ admission after deductible	Precertification required. Failure to precertify may result in a penalty up to $500. Nonparticipating Provider: Inpatient care facility fees are limited to a maximum benefit of $600 per day.
	Physician/surgeon fee	30% coinsurance/ admission after deductible	50% coinsurance/ admission after deductible	

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay/visit	50% coinsurance/visit after deductible	Participating Provider: Deductible does not apply.
	Mental/Behavioral health inpatient services	30% coinsurance/ admission after deductible	50% coinsurance/ admission after deductible	Precertification required. Failure to precertify may result in a penalty up to $500. Nonparticipating Provider: Inpatient care facility fees are limited to a maximum benefit of $600 per day.
	Substance use disorder outpatient services	$40 copay/visit	50% coinsurance/visit after deductible	Participating Provider: Deductible does not apply.
	Substance use disorder inpatient services	30% coinsurance/ admission after deductible	50% coinsurance/ admission after deductible	For detoxification only. Precertification required. Failure to precertify may result in a penalty up to $500. Nonparticipating Provider: Inpatient care facility fees are limited to a maximum benefit of $600 per day.
If you are pregnant	Prenatal and first postnatal visit	Prenatal: No Charge First Postnatal: 30% coinsurance/visit after deductible	50% coinsurance/visit after deductible	Any non-routine obstetrical care is subject to the normal cost share. Participating Provider: Deductible does not apply to Prenatal care.
	Delivery and all inpatient services	30% coinsurance/ admission after deductible	50% coinsurance/ admission after deductible	Precertification required. Failure to precertify may result in a penalty up to $500. Nonparticipating Provider: Inpatient care facility fees are limited to a maximum benefit of $600 per day.
If you need help recovering or have other special health needs	Home health care	20% coinsurance/visit after deductible	20% coinsurance/visit after deductible	Subject to $50 deductible combined per calendar year, in addition to Calendar Year Deductible Limited to 100 visits combined per calendar year. Private duty nursing not covered.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Nonparticipating Provider	Limitations & Exceptions
	Rehabilitation services	Outpatient: 30% coinsurance/visit after deductible Inpatient: 30% coinsurance/admission after deductible	Outpatient: 50% coinsurance/visit after deductible Inpatient: 50% coinsurance/admission after deductible	Precertification required. Failure to precertify may result in a penalty up to $500. Limited to 60 visits per calendar year combined for Physical, Speech & Occupational Therapy. Limits do not apply to services related to Autism Spectrum Disorders. Nonparticipating Provider: Inpatient care facility fees are limited to a maximum benefit of $600 per day.
	Habilitation services	$40 copay/visit	50% coinsurance/visit after deductible	Limited to services to maintain/ improve skills or functioning at risk due to medical deficits. Cost share applies to Outpatient services. Precertification required. Failure to precertify may result in a penalty up to $500.
	Skilled nursing care	30% coinsurance/ admission after deductible	50% coinsurance/ admission after deductible	Precertification required. Failure to precertify may result in a penalty up to $500. Limited to 60 days combined per calendar year. Nonparticipating Provider: Inpatient care facility fees are limited to a maximum benefit of $600 per day.
	Durable medical equipment	30% coinsurance/item after deductible	50% coinsurance/item after deductible	Precertification required. Failure to precertify may result in a penalty up to $500. Certain items limited to a benefit maximum of $2,000 combined per calendar year.
	Hospice service	30% coinsurance/service after deductible	50% coinsurance/service after deductible	Precertification required. Failure to precertify may result in a penalty up to $500. Combined maximum benefit while insured of 180 days.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered.
	Glasses	Not Covered	Not Covered	Not Covered.
	Dental check-up	Not Covered	Not Covered	Not Covered.

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.)

- Bariatric surgery
- Chiropractic Care and Acupuncture
- Cosmetic surgery
- Glasses
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- Routine foot care (without diabetes)
- 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.)

- Infertility treatment (up to $1,000 per calendar year)

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 1-800-788-0710. 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: Dell Health Services by calling 1-800-392-8649.

You may also contact the California Department of Insurance at 1-800-927-4357 (1-800-927-HELP) or you may write to California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013. Or you can log in to the California Department of Insurance website at www.insurance.ca.gov.

Additionally, a 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

mail to:helpline@dmhc.ca.gov

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0710.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-788-0710.

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 1-800-788-0710.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-788-0710.

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 $4,490
- Patient pays $ 3,050

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	$20
Coinsurance	$1,880
Limits or exclusions	$150
Total	$3,050

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

- Amount owed to providers: $5,400
- Plan pays $3,180
- Patient pays $ 2,220

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	$820
Coinsurance	$320
Limits or exclusions	$80
Total	$2,220

Note: The coverage example was calculated assuming that the member used Participating providers for all services, drugs, and DME.

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.