**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 **1-888-865-5813**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$500** Individual / **$1,000** Family<br>Does not apply to preventive care services | 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, 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. For a list of participating providers see www.kp.org **or call 1-888-865-5813** | 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. Written approval is required to see most 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 Kaiser Permanente at **1-888-865-5813/TTY/TDD 711** or visit us 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 1-888-865-5813/**TTY/TDD 711** 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% coinsurance | Not covered | If you receive services in addition to an office visit, additional copayments, deductibles, or coinsurance may apply. After Deductible. |
| | Specialist visit | 20% coinsurance | Not covered | If you receive services in addition to an office visit, additional copayments, deductibles, or coinsurance may apply. After Deductible. |
| | Other practitioner office visit | 20% coinsurance | Not covered | Coverage limited to 20 visits per year for chiropractic and acupuncture services. After Deductible. |
| | Preventive care/screening/ immunization | No charge | Not covered | Not subject to overall deductible. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge office visit;<br>20% coinsurance outpatient setting | Not covered | Not subject to overall deductible in office setting. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance per procedure in office and outpatient setting | Not covered | After Deductible. |
| **If you need drugs to treat your illness or condition** | Generic drugs | $10 per prescription(retail);<br>$20 per prescription (network pharmacies);<br>$20 per prescription (mail order) | Not covered | Covers up to a 30 day supply (retail); 31-90 day supply (mail order). Network Pharmacies limited to one time fill. No charge for contraceptives (subject to formulary guidelines). Not subject to overall 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. | Preferred brand drugs | $20 per prescription(retail);<br>$30 per prescription (network pharmacies);<br>$40 per prescription (mail order) | Not covered | Covers up to a 30 day supply (retail); 31-90 day supply (mail order). Network Pharmacies limited to one time fill. Not subject to overall deductible |
| | Non-preferred brand drugs | $40 per prescription(retail);<br>$50 per prescription (network pharmacies);<br>$80 per prescription (mail order) | Not covered | |
| | Specialty drugs | 25% coinsurance; $150 per prescription maximum (retail and network pharmacies) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | After Deductible. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | |
| **If you need immediate medical attention** | Emergency room services | 20% coinsurance | | This cost sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "if you have a hospital stay" for inpatient Cost Sharing) After Deductible. |
| | Emergency medical transportation | 20% coinsurance | | After Deductible. |
| | Urgent care | 20% coinsurance | Not covered | Non-participating provider urgent care covered only if you are temporarily outside of our service area. If you receive services in addition to an office visit, additional copayments, deductibles, or coinsurance may apply. After Deductible. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | After Deductible. |
| | Physician/surgeon fee | 20% coinsurance | Not covered | After Deductible. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 20% coinsurance | Not covered | If you receive services in addition to an office visit, additional copayments, deductibles, or coinsurance may apply. After Deductible. |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Plan Provider | Non Plan Provider | |
| | Mental/Behavioral health inpatient services | 20% coinsurance | Not covered | After Deductible. |
| **If you have mental health, behavioral health, or substance abuse needs** | Substance use disorder outpatient services | 20% coinsurance | Not covered | If you receive services in addition to an office visit, additional copayments, deductibles, or coinsurance may apply. After Deductible. |
| | Substance use disorder inpatient services | 20% coinsurance | Not covered | After Deductible. |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | Not covered | No cost share will be collected at time of service for prenatal visits and first post-partum visit. Cost share for these services will be collected as part of delivery charge. After Deductible. |
| | Delivery and all inpatient services | 20% coinsurance | Not covered | After Deductible. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not covered | Coverage is unlimited visits per year. Private duty nursing not covered. After Deductible. |
| | Rehabilitation services | 20% coinsurance | Not covered | Coverage is limited to 20 outpatient visits per therapy per year combined for Occupational, Physical and Speech therapy. Children 6 and under with ASD no visit limits required. After Deductible. |
| | Habilitation services | 20% coinsurance | Not covered | Coverage is limited to 20 outpatient visits per therapy per year combined for Occupational, Physical and Speech therapy. Children 6 and under with ASD no visit limits required. After Deductible |
| | Skilled nursing care | 20% coinsurance | Not covered | Coverage is limited to 100 days per year. After Deductible. |
| | Durable medical equipment | 20% coinsurance | Not covered | Coverage is unlimited to items on our DME formulary. 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 |
|---|---|---|---|---|
| | Hospice service | 20% coinsurance | Not covered | After Deductible. |
| **If your child needs dental or eye care** | Eye exam | 20% coinsurance | Not covered | After Deductible. |
| | Glasses | Not covered | Not covered | No coverage for glasses |
| | Dental check-up | Not covered | Not covered | No dental coverage |

## 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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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
- Chiropractic care
- Infertility treatment
- 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 1-888-865-5813. 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: Member Services at 1-888-865-5813, Monday through Friday, 7:00 AM to 7:00 PM. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. You may contact the State Department of Insurance at: **Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, 800-656-2298**, http://www.oci.ga.gov/ConsumerService/. Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court. You may contact the State Department of Insurance as shown above.

## 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:** SPANISH (Español): Para obtener asistencia en Español, llame al 1-888-865-5813 or TTY/TDD 711

**TAGALOG**: TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-865-5813 or TTY/TDD 711

**CHINESE**: 若有問題：請撥打1-888-865-5813 或 TTY/TDD 711

**NAVAJO**: NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-865-5813 or 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** $6,020
- **Patient pays** $1,520

### 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 | $500 |
| Copays | $20 |
| Coinsurance after deductible | $800 |
| Limits or exclusions | $200 |
| **Total** | **$1,520** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,020
- **Patient pays** $ 1,380

### 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 | $500 |
| Copays | $600 |
| Coinsurance after deductible | $200 |
| Limits or exclusions | $80 |
| **Total** | **$1,380** |

Total amounts above are based on subscriber only coverage

# 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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