



**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](http://www.kp.org/plandocuments) or by calling 1-888-865-5813.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$2,500 individual/\$5,000 family; Does not apply to preventive care	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,850 individual/\$13,700 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. For a list of <u>plan providers</u> , see <a href="http://www.kp.org">www.kp.org</a> or call 1-888-865-5813.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes. Written approval is required to see most specialists.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
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 <u>excluded services</u> .

**Questions:** Call 1-888-865-5813, 711(TTY/TDD) or visit us at [www.kp.org](http://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](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-888-865-5813 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 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	\$40 per visit	Not covered	If you receive services in addition to an office visit, additional copayments, deductibles, or coinsurance may apply. Not subject to the overall deductible.
	Specialist visit	\$60 per visit	Not covered	If you receive services in addition to an office visit, additional copayments, deductibles, or coinsurance may apply. Not subject to the overall deductible.
	Other practitioner office visit	\$60 per visit	Not covered	Coverage is limited to 20 visits per year for chiropractic services (spinal manipulation only). Not subject to the overall deductible.
	Preventive care/screening/immunization	No charge	Not covered	Coverage is limited to 1 exam per year. Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance for Radiology in office; \$0 per visit for Lab in office	Not covered	35% coinsurance for outpatient services for Radiology and LAB.
	Imaging (CT/PET scans, MRI's)	25% coinsurance office; 35% coinsurance outpatient setting	Not covered	—————none—————

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
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.kp.org">www.kp.org</a> .	Generic drugs	\$20 per prescription(retail); \$30 per prescription (network pharmacies); \$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. No charge for contraceptives (subject to formulary guidelines). Not subject to the overall deductible.
	Preferred brand drugs	\$40 per prescription(retail); \$50 per prescription (network pharmacies); \$80 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 the overall deductible.
	Non-preferred brand drugs	\$60 per prescription(retail); \$70 per prescription (network pharmacies); \$120 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 the overall deductible.
	Specialty drugs	25% coinsurance	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 the overall deductible.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not covered	—————none—————
	Physician/surgeon fees	25% coinsurance	Not covered	—————none—————

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 immediate medical attention	Emergency room services	25% coinsurance	25% coinsurance	—————none—————
	Emergency medical transportation	25% coinsurance	25% coinsurance	—————none—————
	Urgent care	\$80 per visit	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. Not subject to the overall deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	—————none—————
	Physician/surgeon fee	25% coinsurance	Not covered	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40 per visit (individual); \$20 per visit (group)	Not covered	If you receive services in addition to an office visit, additional copayments, deductibles, or coinsurance may apply. Not subject to the overall deductible.
	Mental/Behavioral health inpatient services	25% coinsurance	Not covered	—————none—————
	Substance use disorder outpatient services	\$40 per visit (individual); \$20 per visit (group)	Not covered	If you receive services in addition to an office visit, additional copayments, deductibles, or coinsurance may apply. Not subject to the overall deductible.
	Substance use disorder inpatient services	25% coinsurance	Not covered	—————none—————
If you are pregnant	Prenatal and postnatal care	25% 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
	Delivery and all inpatient services	25% coinsurance	Not covered	—————none—————

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
<b>If you need help recovering or have other special health needs</b>	Home health care	25% coinsurance	Not covered	Coverage is limited to 120 visits per year. Private duty nursing not covered.
	Rehabilitation services	25% coinsurance (outpatient) 25% coinsurance (inpatient)	Not covered	Coverage is limited to 20 outpatient visits per year combined for Occupational and Physical therapy. Speech therapy is limited to 20 outpatient visits per year. Coverage for Habilitation services are combined with Rehabilitation services.
	Habilitation services	25% coinsurance (outpatient) 25% coinsurance (inpatient)	Not covered	See Rehabilitation Services for limitation details
	Skilled nursing care	25% coinsurance	Not covered	Coverage is limited to 150 days per year.
	Durable medical equipment	25% coinsurance	Not covered	Coverage is unlimited to items on our DME formulary.
	Hospice service	No charge	Not covered	Not subject to the overall deductible.
<b>If your child needs dental or eye care</b>	Eye exam	\$40 per visit for refractive exam	Not covered	Coverage is limited to 1 exam per year. Not subject to the overall deductible.
	Glasses	No charge	Not covered	Eye wear provided to children up to age 18. Coverage includes one pair of glasses per year with selection from collection frames and contact lenses. Not subject to the overall deductible.
	Dental check-up	0% coinsurance	Not covered	Members age 18 and younger Pediatric Dental embedded

## 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.)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
|--|--|---|

### 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.)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"><li>• Chiropractic care</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li></ul> |  |
|---|--|--|

## 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](http://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](http://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](http://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 (Español): Para obtener asistencia en Español, llame al **1-888-865-5813**

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-865-5813**

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-888-865-5813**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwíijigo holne' **1-888-865-5813**

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## 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 \$3,620
- Patient pays \$3,920

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient Pays:

Deductibles	\$2,500
Copays	\$20
Coinsurance	\$1,200
Limits or exclusions	\$200
<b>Total</b>	<b>\$3,920</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$3,620
- Patient pays \$1,780

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient Pays:

Deductibles	\$100
Copays	\$1,600
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,780</b>

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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