




**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/cuhealthplan](http://www.KP.org/cuhealthplan) or by calling 1-866-213-3062.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your 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?	\$6,850 Individual/ \$13,700 Family	The <b>out-of-pocket limit</b> 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?	Payments for prescription drugs, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
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 <a href="http://www.kp.org/cuhealthplan">www.kp.org/cuhealthplan</a> or call 1-866-213-3062.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .
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 <b>excluded services</b> .

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**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 an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 copayment	Not Covered	---none---
	Specialist visit	\$40 copayment	Not Covered	---none---
	Other practitioner office visit	\$30 copayment for Chiropractic Services	Not Covered	20 visits per Plan year
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Office visit cost share applies if performed in the Office
	Imaging (CT/PET scans, MRIs)	\$100 Per Procedure	Not Covered	---none---

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs	Retail: \$15 Mail: \$30	Not Covered	Retail copayment covers up to a 30-day supply. Mail Order copayment covers up to a 90-day supply. No charge for Smoking Cessation drugs with a prescription. Members diagnosed with diabetes may be eligible to have diabetic medication & supplies obtained at in network pharmacies with no applicable copayment. Please contact customer service for additional information.
	Preferred brand drugs	Retail: \$35 Mail: \$70	Not Covered	Retail copayment covers up to a 30-day supply. Mail Order copayment covers up to a 90-day supply. No charge for Smoking Cessation drugs with a prescription. Members diagnosed with diabetes may be eligible to have diabetic medication & supplies obtained at in network pharmacies with no applicable copayment. Please contact customer service for additional information.
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	Up to a maximum of \$75 per Rx for 30 days. Includes self administered injectables.

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	\$250 copayment	Not Covered	---none---
<b>If you need immediate medical attention</b>	Emergency room services	\$150 copayment		Copayment is waived if admitted to the hospital.
	Emergency medical transportation	No Charge		---none---
	Urgent care	\$30 copayment		\$150 copayment for urgent care received in an emergency room
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 copayment per day	Not Covered	\$1,000 copay maximum per admission. Prior authorization required.
	Physician/surgeon fee			
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copayment	Not Covered	---none---
	Mental/Behavioral health inpatient services	\$250 copayment per day	Not Covered	\$1,000 copay maximum per admission. Prior authorization required.
	Substance use disorder outpatient services	\$30 copayment	Not Covered	---none---
	Substance use disorder inpatient services	\$250 copayment per day	Not Covered	\$1,000 copay maximum per admission. Prior authorization required.
<b>If you are pregnant</b>	Prenatal and postnatal care	No Charge	Not Covered	---none---
	Delivery and all inpatient services	\$250 copayment per day	Not Covered	\$1,000 copay maximum per admission. Prior authorization required.

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	No Charge	Not Covered	28 hours per week. Additional time up to 35 hours if authorized. Prior authorization required.
	Rehabilitation services	\$30 copayment	Not Covered	20 visits per therapy per Plan year. Visit limits do not apply for the treatment of autism. Prior authorization required.
	Habilitation services	\$30 copayment	Not Covered	20 visits per therapy per Plan year. Visit limits do not apply for the treatment of autism. Prior authorization required.
	Skilled nursing care	No Charge	Not Covered	100 days per Plan year. Prior authorization required.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required.
	Hospice service	No Charge	Not Covered	Prior authorization required.
<b>If your child needs dental or eye care</b>	Eye exam	\$30 Optometrist; \$40 Ophthalmologist	Not Covered	---none---
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not covered	Not Covered	---none---

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

## Excluded Services &amp; 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**.)

- Cosmetic Surgery
- Long Term Care
- Weight Loss Programs (unless in conjunction with approved bariatric surgery plan)
- Dental Care
- Non-emergency care when traveling outside the US
- Heating Aids (for adults)
- Private Duty Nursing

**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.)

- Bariatric Surgery
- Routine Eye Care (Adult)
- Chiropractic Care
- Routine Foot Care
- Infertility Treatment

**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 1-800-402-1236. 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).

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## 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: Administrative Committee, c/o Kaiser Foundation Health Plan, Inc., 20<sup>th</sup> Floor, Ordway Building, 1 Kaiser Plaza, Oakland, CA 94612. You may also contact 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).

## 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 1-866-213-3062.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-213-3062.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-213-3062.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-866-213-3062.

**Your health benefits will be self-insured by your Plan sponsor. Kaiser Permanente Insurance Company will provide certain administrative services for the Plan and will not be an insurer of the Plan or financially liable for health care benefits under the Plan.**

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

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## Coverage Examples

### 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 \$7,120
- Patient pays \$ 420

##### 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	\$0
Co-pays	\$270
Co-insurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$420</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,420
- Patient pays \$ 980

##### 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	\$0
Co-pays	\$900
Co-insurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$980</b>

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## 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.

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