Health Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
KAISER PERMANENTE®: CU Health Plan – Kaiser

Coverage Period: 07/01/2022 – 06/30/2023
Coverage for: Individual / Family | **Plan Type: EPO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/cuhealthplan or call 1-866-213-3062 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.healthcare.gov/sbc-glossary or call 1-866-213-3062 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Not Applicable.**	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$8,700** Individual / **$17,400** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Payments for premium, preauthorization penalties, balance billing charges and health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	**Yes**. See www.kp.org/cuhealthplan or call 1-866-213-3062 (TTY: 711) for a list of plan providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**Yes,** but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 / visit	Not covered	None
	Specialist visit	$40 / visit	Not covered	None
	Preventive care/screening/ immunization	$0 / visit	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$0 / visit	Not covered	Office visit cost share applies if performed in the office.
	Imaging (CT/PET scans, MRIs)	$100 / scan	Not covered	None
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	$15 retail; $30 mail order / prescription	Not covered	Up to a 30-day supply retail or 90-day supply mail order. Subject to formulary guidelines. 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	$35 retail; $70 mail order / prescription	Not covered	
	Non-preferred brand drugs	Not Covered	Not covered	None
	Specialty drugs	20% coinsurance up to $75 / prescription		Up to a 30-day supply. Includes self-administered injectables.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / procedure	Not covered	None
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	$250 / visit		Copayment waived if admitted as an inpatient.
	Emergency medical transportation	$0 / trip		None
	Urgent care	$30 / visit		$250 copayment for urgent care received in

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				the Emergency Room. Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / day up to $1,000 / admission	Not covered	Prior authorization required.
	Physician/surgeon fees	Included in facility fee	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 / individual visit	Not covered	$15 / group visit
	Inpatient services	$250 / day up to $1,000 / admission	Not covered	Prior authorization required.
If you are pregnant	Office visits	$0	Not covered	Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Included in facility fee	Not covered	None
	Childbirth/delivery facility services	$250 / day up to $1,000 / admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	$0 / visit	Not covered	28 hours per week. Additional time up to 35 hours if authorized. Prior authorization required.
	Rehabilitation services	$30 / visit	Not covered	20 visits per therapy per Plan year. Prior authorization required.
	Habilitation services	$30 / visit	Not covered	20 visits per therapy per Plan year. Prior authorization required.
	Skilled nursing care	$0 / day	Not covered	100 days per Plan year. Prior authorization required.
	Durable medical equipment	$0 / item	Not covered	Prior authorization required.
	Hospice services	$0 / visit	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	$30 / Optometrist visit $40 /Ophthalmologist visit	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Dental care (Adult & Child)
- Children's glasses
- Cosmetic surgery
- Hearing aids (Adult)
- Long-term care
- Non-preferred brand drugs
- Non-emergency when traveling outside the US
- Private-duty nursing
- Weight loss programs (unless in conjunction with approved bariatric surgery plan)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 visit limit / year)
- Bariatric surgery
- Chiropractic care (20 visit limit / year)
- Hearing aids (Under age 18; two every 60 months
- Infertility treatment
- Routine eye care (Adult & Child)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below:

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-788-0710 (TTY: 711)
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-213-3062 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-213-3062 (TTY: 711)

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-213-3062 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-213-3062 (TTY: 711)

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 section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist Copayments	$40
Hospital (facility) Copayments	$250
Other Copayments	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist Copayments	$40
Hospital (facility) Copayments	$250
Other Copayments	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist Copayments	$40
Hospital (facility) Copayments	$250
Other Copayments	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

The plan would be responsible for the other costs of these EXAMPLE covered services.