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 **1-800-278-3296**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,000** person/**$12,000** family Does not apply to or count toward preventive care or prescrption drugs.	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. Pharmacy Deductible: **$500** person / **$1,000** family in network. 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**. For **Plan Provider** **$6,500** person / **$13,000** 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, 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 **preferred providers**, see **kp.org** or call **1-800-278-3296**.	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**. All services outside of primary care with the exception of obstetrics and gynecology, mental health, chemical dependency, and optometry require a referral.	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 **1-800-278-3296** or **711** (TTY) or visit us at **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 **1-800-278-3296** or **711** (TTY) 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 **preferred 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	$70 Copay	Not Covered	After deductible. (Deductible waived for the first three non-preventive visits including urgent care visits or outpatient Mental Health/Substance Use Disorder visits)
	Specialist visit	$90 Copay	Not Covered	After deductible. (Deductible waived for the first three non-preventive visits including urgent care visits or outpatient Mental Health/Substance Use Disorder visits)
	Other practitioner office visit	$70 Copay	Not Covered	After deductible. (Deductible waived for the first three non-preventive visits including urgent care visits or outpatient Mental Health/Substance Use Disorder visits)
	Preventive care/screening/ immunization	No Charge	Not Covered	Deductible waived. Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	100% Coinsurance after deductible	Not Covered	Lab: $40 Copay (deductible waived); X-ray and Diagnostic Imaging: 100% after deductible up to the out-of-pocket limit
	Imaging (CT/PET scans, MRIs)	100% Coinsurance after deductible	Not Covered	100% coinsurance after deductible up to the out-of-pocket maximum

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 More information about **prescription drug coverage** is available at kp.org/formulary .	Generic drugs	100% Coinsurance	Not Covered	After pharmacy deductible. Up to $500 per prescription for up to a 30-day supply at a KP plan pharmacy. Female contraceptives are no charge.
	Preferred brand drugs	100% Coinsurance	Not Covered	After pharmacy deductible. Up to $500 per prescription for up to a 30-day supply at a KP plan pharmacy. Female contraceptives are no charge.
	Non-preferred brand drugs	100% Coinsurance	Not Covered	After pharmacy deductible. Up to $500 per prescription for up to a 30-day supply at a KP plan pharmacy. Female contraceptives are no charge.
	Specialty drugs	100% Coinsurance	Not Covered	After pharmacy deductible. Up to $500 per prescription for up to a 30-day supply at a KP plan pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% Coinsurance after deductible	Not Covered	100% after deductible up to the out-of pocket limit. Includes facility, physician and surgical fee.
	Physician/surgeon fees	100% Coinsurance after deductible	Not Covered	100% after deductible up to the out-of pocket limit. Includes facility, physician and surgical fee.
If you need immediate medical attention	Emergency room services	100% Coinsurance after deductible	100% Coinsurance after deductible	100% after deductible up to the out-of-pocket limit
	Emergency medical transportation	100% Coinsurance after deductible	100% Coinsurance after deductible	100% after deductible up to the out-of-pocket limit
	Urgent care	$70 Copay	$70 Copay	After deductible. (Deductible waived for the first three non-preventive visits including urgent care visits or outpatient Mental Health/Substance Use Disorder visits)

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 have a hospital stay	Facility fee (e.g., hospital room)	100% Coinsurance after deductible	Not Covered	100% after deductible up to the out-of-pocket limit. Includes physician, facility and surgical fee.
	Physician/surgeon fee	100% Coinsurance after deductible	Not Covered	100% after deductible up to the out-of-pocket limit. Includes physician, facility and surgical fee.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$70 Copay/visit and 100% up to $70 Copay after deductible for other outpatient services. Group visits are $35 Copay per visit after deductible.	Not Covered	After deductible. (Deductible waived for the first three non-preventive visits including urgent care visits or outpatient Mental Health/Substance Use Disorder visits)
	Mental/Behavioral health inpatient services	100% Coinsurance after deductible	Not Covered	100% after deductible up to the out-of-pocket limit. Includes physician, facility and surgical fee.
	Substance use disorder outpatient services	$70 Copay/visit and 100% up to $5 Copay after deductible for other outpatient services. Group visits are $5 Copay per visit after deductible.	Not Covered	After deductible. (Deductible waived for the first three non-preventive visits including urgent care visits or outpatient Mental Health/Substance Use Disorder visits)
	Substance use disorder inpatient services	100% Coinsurance after deductible	Not Covered	100% after deductible up to the out-of-pocket limit. Includes physician, facility and surgical fee.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Routine Prenatal Care: No charge; Postnatal Care: No charge first post partum visit
	Delivery and all inpatient services	100% Coinsurance after deductible	Not Covered	100% after deductible up to the out-of-pocket limit. Includes physician, facility and surgical fee.

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 help recovering or have other special health needs	Home health care	No Charge after deductible	Not Covered	Up to 100 visits per calendar year
	Rehabilitation services	Inpatient: 100% Coinsurance after deductible; Outpatient: $70 Copay	Not Covered	Inpatient: Inpatient: 100% after deductible up to the out-of-pocket limit. Includes physician, facility and surgical fee; Outpatient: Deductible waived; Outpatient: Deductible waived
	Habilitation services	Inpatient: 100% Coinsurance after deductible; Outpatient: $70 Copay	Not Covered	Inpatient: 100% after deductible up to the out-of-pocket limit. Includes physician, facility and surgical fee; Outpatient: Deductible waived
	Skilled nursing care	100% Coinsurance after deductible	Not Covered	100% after deductible up to the out-of-pocket limit. Up to 100 days per benefit period.
	Durable medical equipment	100% Coinsurance after deductible	Not Covered	100% after deductible up to the out-of-pocket limit. Most items are not covered. See the durable medical formulary guidelines for detail.
	Hospice service	No Charge	Not Covered	Deductible waived
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	————————none————————
	Glasses	No Charge	Not Covered	Coverage is limited to one pair of glasses per year with selection from collection frames.
	Dental check-up	No Charge	Not Covered	Limited to two check-ups per year. Covered by Delta Dental.

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.)

- Chiropractic Care
- Cosmetic Surgery
- Hearing Aids
- Infertility Treatment
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)
- 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 • Bariatric Surgery	• Routine Foot Care with limits • Routine Hearing Tests	• Voluntary Termination of Pregnancy

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-278-3296. You may also contact your state insurance department at 1-888-466-2219.

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: 1-800-278-3296. You may also contact your state consumer assistance program at 1-888-466-2219

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 1-800-278-3296 or TTY/TDD 711.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 or TTY/TDD 711.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-278-3296 or TTY/TDD 711.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 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** $1,320
- **Patient pays** $6,220

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	$6000
Copays	$0
Coinsurance	$20
Limits or exclusions	$200
Total	**$6,220**

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

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

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	$4900
Copays	$200
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,180**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 1-800-278-3296, TTY/TDD 711.

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.