



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 or by calling **1-855-249-5018**.

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Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See Chart on Page 2 for your costs for services this plan covers.
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. \$3,500 person / \$9,400 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 (unless balance-billing is prohibited), and health care this plan does not 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 <u>specific</u> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of <u>plan providers</u> , see www.kp.org or call 1-855-249-5018 .	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 5. See your policy or plan document for additional information about <u>excluded services</u> .

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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 **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 per visit	Not covered	Waived for child under age 5
	Specialist visit	\$25 per visit	Not covered	_____none_____
	Other practitioner office visit	Not covered	Not covered	No coverage for chiropractic or acupuncture care
	Preventive care/ screening/ immunization	No charge	Not covered	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	_____none_____
	Imaging (CT/PET scans, MRI's)	\$75 per test	Not covered	_____none_____

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.kp.org.</p>	Generic drugs	\$15 per prescription at Plan Pharmacy and Mail Order; \$25 per prescription at Participating Pharmacy	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2.5 copays through Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	\$30 per prescription at Plan Pharmacy and Mail Order; \$40 per prescription at Participating Pharmacy	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2.5 copays through Mail Order. No charge for women's preventive contraceptives.
	Non-preferred brand drugs	\$50 per prescription at Plan Pharmacy and Mail Order; \$55 per prescription at Participating Pharmacy	Not covered	Up to a 30-day supply; Up to a 90-day supply for 2.5 copays. No charge for women's preventive contraceptives.
	Specialty drugs	Applicable Generic, Preferred, and Non-Preferred copayments	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2.5 copays through Mail Order. No charge for women's preventive contraceptives.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	\$50 per visit	Not covered	_____none_____
	Physician/surgeon fees	Included in facility fee	Not covered	_____none_____
<p>If you need immediate medical attention</p>	Emergency room services	\$150 per visit	\$150 per visit	Waived if admitted as inpatient
	Emergency medical transportation	\$50 per encounter	\$50 per encounter	_____none_____
	Urgent care	\$25 per visit	\$25 per visit	Non-plan providers are covered only outside the service area

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 per admission	Not covered	Emergency admissions covered for non-plan providers
	Physician/surgeon fee	Included in facility fee	Not covered	Emergency services covered for non-plan providers
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 per individual visit; \$7 per group visit	Not covered	No coverage for psychological testing for ability, aptitude, intelligence or interest.
	Mental/Behavioral health inpatient services	\$500 per admission	Not covered	_____none_____
	Substance use disorder outpatient services	\$15 per individual visit; \$7 per group visit	Not covered	_____none_____
	Substance use disorder inpatient services	\$500 per admission	Not covered	_____none_____
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy
	Delivery and all inpatient services	\$500 per admission	Not covered	_____none_____

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	_____none_____
	Rehabilitation services	\$500 per inpatient admission; \$25 per outpatient visit	Not covered	Outpatient: Limited up to 90 consecutive days of treatment per injury, incident or condition per year
	Habilitation services	\$500 per inpatient admission; \$25 per outpatient visit	Not covered	Coverage is limited to child up to age 3
	Skilled nursing care	\$500 per admission	Not covered	Coverage is limited to 100 days per year
	Durable medical equipment	No charge	Not covered	_____none_____
	Hospice service	No charge	Not covered	_____none_____
If your child needs dental or eye care	Eye exam	\$15 per Optometrist visit; \$25 per Ophthalmologist visit	Not covered	_____none_____
	Glasses	No charge	Not covered	1 pair of glasses per year limited to single or bifocal lenses or 1st purchase of contact lenses per year or 2 pair per eye per year medically necessary contacts (from select group of frames and contacts)
	Dental check-up	\$30 per visit	Not covered	Copayment applies to preventative services. Discount fees apply to other services.

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"> • Acupuncture • Chiropractic care • Cosmetic surgery 	<ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S.
	<ul style="list-style-type: none"> • Private-duty nursing • Routine Foot Care

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 \$7,240**
- **Patient pays \$300**

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	\$0
Copays	\$100
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$300

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,520**
- **Patient pays \$880**

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	\$0
Copays	\$800
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$880

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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