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 855-249-5018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,250** person/**$2,500** family	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?	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?	Yes. **$5,000** person/**$10,000** 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, balance-billed charges, and 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 plan providers, go to www.kp.org or call 855-249-5018.	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.	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**.

- **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	$30/visit after deductible	Not covered	——————none——————
	Specialist visit	$40/visit after deductible	Not covered	——————none——————
	Other practitioner office visit	Chiropractic Care: $40/visit after deductible	Not covered	For members age 12 and older
	Preventive care/screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org	Generic drugs	Plan Pharmacy: $25; Participating Pharmacy: $35; Mail Order: $25	Not covered	Copay is after deductible. Up to a 30-day supply; Up to a 90-day supply for 2 copays at Plan, Participating Pharmacies, and Mail Order. No charge for women's preventive contraceptives.
	Preferred brand drugs	Plan Pharmacy: $50; Participating Pharmacy: $60; Mail Order: $50	Not covered	
	Non-preferred brand drugs	Plan Pharmacy: $75; Participating Pharmacy: $85; Mail Order: $75	Not covered	
	Specialty drugs	Applicable Generic, Preferred, and Non-Preferred copayments	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	——————none——————
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	10% coinsurance after deductible	10% coinsurance after deductible	——————none——————
	Emergency medical transportation	No charge after deductible	No charge after deductible	——————none——————
	Urgent care	$40/visit after deductible	$40/visit after deductible	Non-plan providers are covered only outside the service area
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Emergency admissions covered for non-plan providers
	Physician/surgeon fee	10% coinsurance after deductible	Not covered	Emergency services covered for non-plan providers

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Individual: $25/visit Group: $10/visit	Not covered	Copay is after deductible. Excludes psychological testing for ability, aptitude, intelligence or interest
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	Not covered	Excludes psychiatric residential treatment
	Substance use disorder outpatient services	Individual: $25/visit Group: $10/visit	Not covered	Copay is after deductible.
	Substance use disorder inpatient services	10% coinsurance after deductible	Not covered	Excludes psychiatric residential treatment
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy
	Delivery and all inpatient services	10% coinsurance after deductible	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not covered	Limited to 90 visits up to 4 hours per visit
	Rehabilitation services	Inpatient: 10% coinsurance; Outpatient: $40/visit after deductible	Not covered	Inpatient: None. Outpatient: Outpatient Cardiac Rehab is limited to 90 consecutive days; Pulmonary Rehab: Limited to 1 program/lifetime.
	Habilitation services	Inpatient: 10% coinsurance; Outpatient: $40/visit after deductible	Not covered	——————none——————
	Skilled nursing care	10% coinsurance after deductible	Not covered	Limited to 60 days per contract year
	Durable medical equipment	10% coinsurance after deductible	Not covered	——————none——————
	Hospice service	10% coinsurance after deductible	Not covered	Limited to 180 days per eligibility period

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 your child needs dental or eye care	Eye exam	Optometrist: $30/visit after deductible Ophthalmologist: $40/visit after deductible	Not Covered	One exam/contract year
	Glasses	No charge	Not covered	1 Pair /year (select group of frames) Limited to single vision or bifocal lenses Contacts limited to 3 months supply from selected list
	Dental check-up	Covered per fee schedule	Not Covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per calendar yr; 2 bitewing x-rays per yr; 1 set of full mouth x-rays every 5 yrs.

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.)

- Acupuncture
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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
- Chiropractic care (Members age 12 or older)
- Dental care (Adult)
- Routine eye care (Adult)
- Weight loss programs

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 1-855-249-5018. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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, contact the plan at 1-855-249-5018. You may also contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the District of Columbia Healthcare Finance Office of the Ombudsman at 1-877-685-6391 or email healthcareombudsman@dc.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 855-249-5018 or TTY/TDD 1-301-879-6380

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-249-5018 or TTY/TDD 1-301-879-6380

CHINESE: 若有問題：請撥打855-249-5018 或 TTY/TDD 1-301-879-6380

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-249-5018 or TTY/TDD 1-301-879-6380

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** $5,720
- **Patient pays** $1,820

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	$1,300
Copays	$20
Coinsurance	$300
Limits or exclusions	$200
Total	**$1,820**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,820
- **Patient pays** $2,580

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	$1,300
Copays	$1,100
Coinsurance	$100
Limits or exclusions	$80
Total	**$2,580**

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.