



**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 <http://my.kaiserpermanente.org/ca/cafiw> or by calling 1-800-278-3296.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$250</b> Individual/ <b>\$500</b> 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 <u>deductibles</u> for specific services?	Yes, Fee-For-Service Dental: <b>\$50</b> individual/ <b>\$150</b> family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	<b>Yes, \$2,000</b> Individual/ <b>\$4,000</b> 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, health care this plan doesn't cover, and cost sharing for certain services listed in plan documents.	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?	<b>No</b>	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	<b>Yes.</b> For a list of <u>plan providers</u> , see <a href="http://my.kaiserpermanente.org/ca/cafiw">http://my.kaiserpermanente.org/ca/cafiw</a> or call 1-800-278-3296.	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, preferred, 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> ?	<b>Yes</b> , written referral required but you may self-refer to certain 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?	<b>Yes</b>	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-278-3296 or 1-800-777-1370 (TTY), or visit us at <http://my.kaiserpermanente.org/ca/cafiw>  
 If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-800-278-3296 or 1-800-777-1370 (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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$20 per visit	Not covered	Deductible waived
	Specialist visit	\$20 per visit	Not covered	Deductible waived. Services related to infertility covered at 50% coinsurance.
	Other practitioner office visit	\$15 per visit for chiropractic services, \$20 per visit for acupuncture	Not covered	Deductible waived Up to 30 visit(s) per calendar year for chiropractic services. Physician referred acupuncture.
	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)	X-ray: No charge Lab tests: No charge	Not covered	Deductible waived
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Deductible waived

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan 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 per prescription for 1 to 30 day(s); Mail Order: Usually two times the retail cost sharing for up to a 100 day supply	Not covered	Deductible waived. Retail: \$30 per prescription for 31 to 60 day(s), \$45 per prescription for 61 to 100 day(s). In accordance with formulary guidelines, certain drugs may be covered at a different cost share
	Preferred brand drugs	\$30 per prescription for 1 to 30 day(s); Mail Order: Usually two times the retail cost sharing for up to a 100 day supply	Not covered	Deductible waived. Retail \$60 per prescription for 31 to 100 day(s), \$90 per prescription for 61 to 100 day(s). In accordance with formulary guidelines, certain drugs may be covered at a different cost share
	Non-preferred brand drugs	Same as preferred brand drugs	Not covered	Same as Preferred brand drugs when approved through exception process.
	Specialty drugs	Same as preferred brand drugs	Not covered	Same as Preferred brand drugs when approved through exception process.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance per procedure	Not covered	After deductible
	Physician/surgeon fees	10% coinsurance per procedure	Not covered	After deductible
<b>If you need immediate medical attention</b>	Emergency room services	10% coinsurance per visit		After deductible
	Emergency medical transportation	\$50 per trip		Deductible waived
	Urgent care	\$20 per visit		Deductible waived. Non-Plan providers covered when outside the service area.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance per admission	Not covered	After deductible
	Physician/surgeon fee	10% coinsurance per admission	Not covered	After deductible
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 per individual visit; \$10 per group visit	Not covered	Deductible waived
	Mental/Behavioral health inpatient services	10% coinsurance per admission	Not covered	After deductible
	Substance use disorder outpatient services	<b>Kaiser:</b> \$20 per individual visit; \$5 per group visit; <b>Fee-For-Service (Employee Only) :</b> Premier Plan: \$20 per visit;	<b>Kaiser:</b> Not Covered  <b>Fee-For-Service:</b> Not covered.	Deductible waived at a Kaiser provider or Fee-For-Service <b>contract provider</b> .  Deductible applies to <b>non-contract provider</b> services.
	Substance use disorder inpatient services	<b>Kaiser:</b> 10% coinsurance per admission <b>Fee-For-Service (Employee Only):</b> 10% coinsurance	<b>Kaiser:</b> Not Covered  <b>Fee-For-Service:</b> Not covered.	Deductible applies for both Kaiser and Fee-For-Service benefits;  <i>Fee-For-Service benefits must be <b>Preauthorized by MHN</b> or you will pay an additional 10% coinsurance.</i>
If you are pregnant	Prenatal and postnatal care	Prenatal care: No charge Postnatal care: No charge	Not covered	Deductible waived. Prenatal: Cost sharing is for routine preventive care only. Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	10% coinsurance per admission	Not covered	After deductible

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	No charge	Not covered	Deductible waived. Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits per calendar year.
	Rehabilitation services	Inpatient: 10% coinsurance per admission. Outpatient: \$20 per day	Not covered	Inpatient: after deductible Outpatient: Deductible waived
	Habilitation services	\$20 per day	Not covered	Deductible waived
	Skilled nursing care	No charge	Not covered	Deductible waived. Up to a 100 day maximum per benefit period
	Durable medical equipment	10% coinsurance per item	Not covered	Deductible waived. Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No charge	Not covered	Deductible waived. Limited to a diagnosis of terminal illness with a life expectancy of twelve months or less.
<b>If your child needs dental or eye care</b>	Eye exam	<b>Kaiser:</b> No charge <b>VSP:</b> \$25 co-payment; <b>Spectera:</b> \$10 co-payment	<b>Kaiser:</b> Not covered <b>VSP or Spectera:</b> 100% coinsurance on charges above the allowed amount	Deductible does not apply under any Plan.  You must enroll in VSP or Spectera to have coverage under one of those Plans. Exam limited to once every 12 months.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
	Glasses	<p><b>Kaiser:</b> Not covered</p> <p><b>VSP:</b> 100% of charges over the Plan allowance for frames.</p> <p><b>Spectera:</b> \$10 co-payment plus 100% of charges over the Plan allowance for frames;</p>	<p><b>Kaiser:</b> Not covered</p> <p><b>VSP or Spectera:</b> 100% coinsurance for charges above allowed amounts</p>	<p>Deductible does not apply under any Plan.</p> <p>You must enroll in Spectera or VSP to have coverage. <b>VSP:</b> glasses (or contacts) allowed once every 12 months; allowance for frames (or contacts) is \$150; <b>Spectera:</b> frames allowed once every 24 months, lenses allowed once every 12 months; allowance for frames is \$130 (\$105 for contacts).</p>
	Dental check-up	<p><b>Kaiser:</b> Not covered</p> <p><b>Fee-for-Service Dental Plan:</b> no charge after \$50 dental deductible. For Dental HMO plans see Open Enrollment Plan Comparison.</p>	<p><b>Kaiser:</b> Not covered</p> <p><b>Fee-for-Service Dental Plan:</b> 20% coinsurance after \$50 dental deductible. <b>Dental HMO plans:</b> Not Covered</p>	<p>Benefits are available through a contract with Delta Dental. Alternatively, you can enroll in one of the Plan's dental HMO plans.</p>

### 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the US</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul>

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.)		
<ul style="list-style-type: none"> <li>• Acupuncture (plan provider referred)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult) (Limitations apply depending on dental Plan)</li> <li>• Hearing aids (allowed amount of \$2,000 per device; once every 3 years)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult) (Limitations apply depending on vision Plan)</li> <li>• Routine foot care</li> </ul>

## 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 1-800-278-3296. 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).

## 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: Kaiser Permanente at 1-800-278-3296 or online at [www.kp.org/memberservices](http://www.kp.org/memberservices). If this coverage is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and the California Department of Insurance at 1-800-927-HELP (4357) or [www.insurance.ca.gov](http://www.insurance.ca.gov).

Additionally, this consumer assistance program can help you file your appeal: Contact  
Department of Managed Health Care Help Center 1-888-466-2219  
980 9th Street, Suite 500 <http://www.healthhelp.ca.gov>  
Sacramento, CA 95814 [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.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 1-800-788-0616, TTY/TDD 1-800-777-1370

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296, TTY/TDD 1-800-777-1370

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585, TTY/TDD 1-800-777-1370

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296, TTY/TDD 1-800-777-1370

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

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## 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 **\$6,420**
- Patient pays **\$1,120**

#### 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	\$300
Copays	\$20
Coinsurance	\$600
Limits or exclusions	\$200
<b>Total</b>	<b>\$1,120</b>

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

- Amount owed to providers: **\$5,400**
- Plan pays **\$4,320**
- Patient pays **\$1,080**

#### 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
Copays	\$900
Coinsurance	\$100
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,080</b>



## 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.