



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?	\$0	See chart on page 2 for your costs for services this plan covers.
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. \$1,500 Individual/\$3,000 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, and cost sharing for certain services listed in plan documents.	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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of plan providers , see www.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, 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 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 1-800-777-1370 (TTY), or visit us at www.kp.org.

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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 **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	\$25 per visit	Not Covered	—————none—————
	Specialist visit	\$25 per visit	Not Covered	Services related to infertility covered at \$25 per visit.
	Other practitioner office visit	\$15 per visit for chiropractic services, \$25 per visit for acupuncture services.	Not Covered	Up to 30 visits per calendar year for chiropractic services, Physician referred acupuncture.
	Preventive care/ screening/ immunization	No Charge	Not Covered	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	—————none—————
	Imaging (CT/PET scans, MRI's)	No Charge	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/formulary .	Generic drugs	Plan pharmacy: \$10 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	Plan pharmacy: \$20 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$25 per procedure	Not Covered	—————none—————
	Physician/surgeon fees	No Charge	Not Covered	—————none—————
If you need immediate medical attention	Emergency room services	\$50 per visit	\$50 per visit	—————none—————
	Emergency medical transportation	No Charge	No Charge	—————none—————
	Urgent care	\$25 per visit	\$25 per visit	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	—————none—————
	Physician/surgeon fee	No Charge	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25 per individual visit; \$12 per group visit	Not Covered	—————none—————
	Mental/Behavioral health inpatient services	No Charge	Not Covered	—————none—————
	Substance use disorder outpatient services	\$25 per individual visit; \$5 per group visit	Not Covered	—————none—————
	Substance use disorder inpatient services	No Charge	Not Covered	—————none—————
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge; Postnatal care: No Charge	Prenatal care: Not covered; Postnatal care: Not covered	Prenatal: Cost sharing is for routine preventive care only; Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	—————none—————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per calendar year.
	Rehabilitation services	Inpatient: No Charge; Outpatient: \$25 per visit	Not Covered	—————none—————
	Habilitation services	\$25 per visit	Not Covered	—————none—————
	Skilled nursing care	No Charge	Not Covered	Up to 100 days maximum per benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.

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	No Charge	Not Covered	—————none—————
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

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"> • Cosmetic surgery • Dental care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine foot care unless medically necessary • 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.)		
<ul style="list-style-type: none"> • Acupuncture (plan provider referred) • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Infertility treatment 	<ul style="list-style-type: none"> • Routine eye care (Adult)

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; 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, you can contact: Kaiser Permanente at 1-800-278-3296 or online at www.kp.org/memberservices.

If this coverage is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

If this coverage is not subject to ERISA, you may also contact the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

Additionally, this consumer assistance program can help you file your appeal:

Department of Managed Health Care Help Center	1-888-466-2219
980 9th Street, Suite 500	www.healthhelp.ca.gov
Sacramento, CA 95814	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 or TTY/TDD 1-800-777-1370

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

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

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 \$7,320
- Patient pays \$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	\$0
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$220

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

- Amount owed to providers: \$5,400
- Plan pays \$4,620
- Patient pays \$780

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	\$700
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$780

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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CITY OF SACRAMENTO

PID:1880 CNTR:1 EU:N/A Plan ID:1557 SBC ID:185414

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Proposed Benefit Summary

1880 CITY OF SACRAMENTO

Principal Benefits for Kaiser Permanente Traditional Plan (1/1/16—12/31/16)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Accumulation Period

The Accumulation Period for this plan is 1/1/16 through 12/31/16 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member).....	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year

Plan Deductible	None
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Professional Services (Plan Provider office visits)

You Pay

Most Primary Care Visits for evaluations and treatment.....	\$25 per visit
Most Specialty Care Visits for consultations, evaluations, and treatment.....	\$25 per visit
Routine physical maintenance exams, including well-woman exams.....	No charge
Well-child preventive exams (through age 23 months).....	No charge
Family planning counseling and consultations.....	No charge
Scheduled prenatal care exams.....	No charge
Routine eye exams with a Plan Optometrist.....	No charge
Hearing exams.....	No charge
Urgent care consultations, evaluations, and treatment.....	\$25 per visit
Most physical, occupational, and speech therapy.....	\$25 per visit

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures.....	\$25 per procedure
Allergy injections (including allergy serum).....	\$3 per visit
Most immunizations (including the vaccine).....	No charge
Most X-rays and laboratory tests.....	No charge
Covered individual health education counseling.....	No charge
Covered health education programs.....	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	No charge
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Emergency Health Coverage

You Pay

Emergency Department visits.....	\$50 per visit
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Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services

You Pay

Ambulance Services.....	No charge
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Prescription Drug Coverage

You Pay

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items at a Plan Pharmacy.....	\$10 for up to a 30-day supply
Most generic refills through our mail-order service.....	\$20 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy.....	\$20 for up to a 30-day supply
Most brand-name refills through our mail-order service.....	\$40 for up to a 100-day supply

Proposed Benefit Summary

(continued)

Durable Medical Equipment (DME)	You Pay
DME items that are essential health benefits in accord with our DME formulary guidelines.....	No charge
DME items that are not essential health benefits in accord with our DME formulary guidelines.....	No charge
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	\$25 per visit
Group outpatient mental health treatment.....	\$12 per visit
Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	\$25 per visit
Group outpatient chemical dependency treatment.....	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
Prosthetic and orthotic devices	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).