Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Coverage Tiers | Plan Type: HMO



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 1-800-278-3296.

Important Questions	Answers	Why this Matters:		
What is the overall deductible?	No	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .		
Are there other deductibles 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-</u> <u>pocket limit</u> on my expenses?	Yes. Individual \$1,500 / Family \$3,000	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, payments for health care this plan doesn't cover and other services outlined in plan documents.	Even though you pay these expenses, they don't count toward the <u>out-of-</u> <u>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 <i>specific</i> covered services, such as office visits.		
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.kp.org or call 1-800-278-3296.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, preferred, or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .		
Do I need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .		
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.		

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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 to request a copy.

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- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common		Your Cost If You	ı Use a	
Medical Event	Services You May Need	Plan Provider	Non-Plan Provider	Limitations & Exceptions
	Primary care visit to treat an injury or illness	\$15 copayment / visit(s)	Not covered	none
If you visit a health	Specialist visit	\$15 copayment / visit(s)	Not covered	none
care <u>provider's</u> office or clinic	Other practitioner office visit	\$15 copayment / visit(s)	Not covered	Up to 30 visit(s) / calendar year for chiropractic care. Acupuncture services by plan provider referral only.
	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
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	Not covered	none
If you need drugs to treat your illness or	Generic drugs	\$10 copayment / prescription(s)	Not covered	
condition  More information	Preferred brand drugs	\$20 copayment / prescription(s)	Not covered	Un to 100 day avanly
about <b>prescription drug coverage</b> is	Non-preferred brand drugs		Not covered	Up to 100-day supply.
available at www.kp.org/formulary.	Specialty drugs		Not covered	

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	\$15 copayment / procedure(s)	Not covered Not covered	none
If you need	Emergency room services	\$50 copayment /	visit(s)	none
immediate medical	Emergency medical transportation	No charge	;	none
attention	Urgent care	\$15 copayment / visit(s)		none
If you have a	Facility fee (e.g., hospital room)	\$100 copayment /	Not covered	none
hospital stay	Physician/surgeon fee	admission(s)	Not covered	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 (Individual), \$7 (Group) copayment / visit(s)	Not covered	none
	Mental/Behavioral health inpatient services	\$100 copayment/ admission(s)	Not covered	none
	Substance use disorder outpatient services	\$15 (Individual), \$5 (Group) copayment / visit(s)	Not covered	none
	Substance use disorder inpatient services	\$100 copayment / admission(s)	Not covered	
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	none
	Delivery and all inpatient services	\$100 copayment / admission(s)	Not Covered	none

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If you need help recovering or have	Home health care	No charge	Not Covered	Up to 3 visit(s) / day, 100 visit(s) / calendar year
	Rehabilitation services	\$15 copayment / day(s)	Not Covered	none
	Habilitation services	\$15 copayment /day(s)	Not Covered	Limited to services to maintain/improve skills or functioning at risk due to medical deficits
other special health needs	Skilled nursing care	No charge	Not Covered	Up to 100 days / benefit period
necus	Durable medical equipment	No charge	Not Covered	Must be in accordance with KP DME formulary guidelines
	Hospice service	No charge	Not Covered	Limited to a diagnosis of terminal illness with a life expectancy of twelve months or less.
If your child needs dental or eye care	Eye exam	\$15 copayment / visit(s)	Not Covered	none
	Glasses	Not covered	Not Covered	none
	Dental check-up	Not covered	Not Covered	none

#### **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>.)

Cosmetic Surgery	Long term care	Private Duty Nurses
Dental	<ul> <li>Non-emergency care when traveling outside the US</li> </ul>	Weight loss program

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 (plan provider referred)
- Infertility

• Chiropractic care

Bariatric surgery

• Routine eye care

Hearing aid(s)

• Routine foot care

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Coverage Period: 01/01/2013 - 12/31/2013

Coverage for: All Coverage Tiers | Plan Type: HMO

#### **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. You may also contact

ERISA GROUPS: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the State's Department of Insurance Contact Information

Additionally, a consumer assistance program can help you file your appeal.

Department of Managed Health Care Help Center 980 9th Street, Suite 500 Sacramento, CA 95814 (888) 466-2219 http://www.healthhelp.ca.gov helpline@dmhc.ca.gov

#### **Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0616.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296.]

Questions: Call 1-800-278-3296 or visit us at www.kp.org.

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#### **Kaiser Permanente: HMO - Actives**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 - 12/31/2013

Coverage for: All Coverage Tiers | Plan Type: HMO

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

Coverage Period: 01/01/2013 - 12/31/2013

Coverage for: All Coverage Tiers | Plan Type: HMO

## **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 \$ 7,270
- Patient pays \$ 270

#### Sample care costs:

Total	\$7,540
Vaccines, other preventive	\$40
Radiology	\$200
Prescriptions	\$200
Laboratory tests	\$500
Anesthesia	\$900
Hospital charges (baby)	\$900
Routine obstetric care	\$2,100
Hospital charges (mother)	\$2,700

#### Patient pays:

i alieni pays.	
Deductibles	\$0
Copays	\$120
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$270

#### **Managing type 2 diabetes**

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$ 4,770
- Patient pays \$630

#### Sample care costs:

Prescriptions	<b>\$2,9</b> 00
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	\$550
Coinsurance	\$0
Limits or exclusions	\$80
Total	<b>\$</b> 630

Coverage Period: 01/01/2013 - 12/31/2013

Coverage for: All Coverage Tiers | Plan Type: HMO

#### **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 innetwork <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> 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 <u>not</u> 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 <u>providers</u> 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 <u>premium</u> you pay. Generally, the lower your <u>premium</u>, the more you'll pay in out-of-pocket costs, such as <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. 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.