Kaiser Permanente: TRADITIONAL HMO PLAN A

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

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

Coverage for: Family | **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 **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 person / $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, payments for 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 *specific* 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 **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, written referral required 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 **800-278-3296** or visit us at **www.kp.org**.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call **800-278-3296** 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 provider's office or clinic	Primary care visit to treat an injury or illness	$10 copayment/visit	Not Covered	——————none——————
	Specialist visit	$10 copayment/visit	Not Covered	Services related to Infertility covered at $10 copayment/visit
	Other practitioner office visit	$15 copayment/visit for chiropractic services,$10 copayment/visit for acupuncture.	Not Covered	Up to 20 visit(s) / Calendar Year for chiropractic services, Physician referred acupuncture.
	Preventive care/screening/immunization	$0 copayment/visit	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)	$0 copayment/ encounter	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$0 copayment/ procedure	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
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	$10 copayment/ prescription	Not Covered	$10 copayment/prescription for 1 to 100 day(s). Certain drugs may be covered at a higher cost share.
	Preferred brand drugs	$20 copayment/ prescription	Not Covered	$20 copayment/prescription for 1 to 100 day(s). Certain drugs may be covered at a higher cost share.
	Non-preferred brand drugs	$20 copayment/ prescription	Not Covered	Same as Preferred brand drug when approved through exception process.
	Specialty drugs	$20 copayment/ prescription	Not Covered	Same as Preferred brand drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 copayment/ procedure	Not Covered	——none——
	Physician/surgeon fees	$0 copayment/ procedure	Not Covered	——none——
If you need immediate medical attention	Emergency room services	$10 copayment/visit	$10 copayment/visit	——none——
	Emergency medical transportation	$0 copayment/trip	$0 copayment/trip	——none——
	Urgent care	$10 copayment/visit	$10 copayment/visit	Non plan providers covered when outside a service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copayment/ admission	Not Covered	——none——
	Physician/surgeon fee	$0 copayment/ admission	Not Covered	——none——

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copayment/visit Individual, $5 copayment/visit Group	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	$0 copayment/ admission	Not Covered	——————none——————
	Substance use disorder outpatient services	$10 copayment/visit Individual, $5 copayment/visit Group	Not Covered	——————none——————
	Substance use disorder inpatient services	$0 copayment/ admission	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal care: $0 copayment/visit, Postnatal care: $0 copayment/visit	Not Covered	Cost sharing for prenatal care is for routine preventive care only. Cost sharing for postnatal care is for the first postnatal visit only.
	Delivery and all inpatient services	$0 copayment/ admission	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you need help recovering or have other special health needs	Home health care	$0 copayment/visit	Not Covered	Up to 2 hour(s) Maximum/ Visit ,Up to 3 visit(s) Maximum/ Day ,Up to 100 visit(s) Maximum/ Calendar Year
	Rehabilitation services	Inpatient:$0 copayment/ admission; Outpatient:$10 copayment/day	Not Covered	——————none——————
	Habilitation services	$10 copayment/day	Not Covered	Limited to services to maintain/ improve skills or functioning at risk due to medical deficits.
	Skilled nursing care	$0 copayment/ admission	Not Covered	Up to 100 day maximum per benefit period.
	Durable medical equipment	$0 copayment/item	Not Covered	Must be in accordance with formulary guidelines
	Hospice service	$0 copayment/ service	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less
If your child needs dental or eye care	Eye exam	$0 copayment/visit	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 excluded services.)

- Cosmetic Surgery
- Hearing Aids
- Long-Term Care
- Non-Emergency Care when Travelling Outside the U.S.
- Private-Duty Nursing
- Routine Dental Services (Adult)
- 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.)		
• Acupuncture with limits • Bariatric Surgery • Chiropractic Care	• Infertility Treatment • Routine Eye Exam (Adult)	• Routine Foot Care

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 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 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 or 1-800-927-HELP (4357) or http://www.insurance.ca.gov.

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

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

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

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 800-278-3296 or TTY/TDD 1-800-777-1370

CHINESE: 若有問題：請撥打 1-800-757-7585 或 TTY/TDD 1-800-777-1370

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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
Co-pays	$20
Co-insurance	$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** $4,720
- **Patient pays** $680

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
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	$680

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.