



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/calpers or by calling 1-800-278-3296.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | \$0 | 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 <u>deductibles</u> 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-pocket limit</u> on my expenses? | Yes. Person: \$1500, Family: \$3000 | 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-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 <u>network of providers</u> ? | 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 <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> ? | Yes | 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? | Yes | Some of the services this plan doesn't cover are listed on page [3 or 4]. See your policy or plan document for additional information about excluded services. |

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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 | | 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 | \$15 copayment / visit(s) | Not covered | ---none--- |
| | Specialist visit | \$15 copayment / visit(s) | Not covered | ---none--- |
| | Other practitioner office visit | \$15 (acupuncture) copayment / visit | Not covered | Chiropractic care: up to 20 visits / calendar year. Acupuncture: 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--- |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | ---none--- |
| 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 | \$5 copayment / prescription for up to 30-day supply | Not covered | \$10 for a 31-to-60-day supply, \$15 for a 61-to 100-day supply. Mail order incentive: \$5 for up to a 30-day supply, \$10 for 31-to-100-day supply. |
| | Preferred brand drugs | \$20 copayment / prescription for up to 30-day supply | Not covered | \$40 for a 31-to-60-day supply, \$60 for a 61-to 100-day supply. Mail order incentive: \$20 for up to a 30-day supply, \$40 for 31-to-100-day supply |
| | Non-preferred brand drugs | | | |
| Specialty drugs | | | | |

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Kaiser Permanente: Copayment HMO

Coverage Period: 1/1/2013-12/31/2013

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

Coverage for: All Coverage Tiers | Plan Type: HMO

| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|--|---|-------------------|---|
| | | Plan Provider | Non-Plan Provider | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$15 copayment / procedure(s) | Not covered | ---none--- |
| | Physician/surgeon fees | | | |
| If you need immediate medical attention | Emergency room services | \$50 copayment / visit(s) | | ---none--- |
| | Emergency medical transportation | No charge | | ---none--- |
| | Urgent care | \$15 copayment / visit(s) | | Urgent care from non-participating providers is covered if a reasonable person would believe that your health would seriously deteriorate if you delayed treatment. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | ---none--- |
| | Physician/surgeon fee | | | |
| 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 | No charge | Not covered | ---none--- |
| | Substance use disorder outpatient services | \$15 individual, \$5 group copayment / visit(s) | Not covered | ---none--- |
| | Substance use disorder inpatient services | No charge | Not covered | |
| If you are pregnant | Prenatal and postnatal care | No charge | Not covered | ---none--- |
| | Delivery and all inpatient services | No charge | Not Covered | ---none--- |

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| 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 | No charge | Not Covered | 3 visits / day. Up to 100 visits per calendar year. Services not subject to deductible. |
| | Rehabilitation services | \$15 copayment / day(s) | Not Covered | ---none--- |
| | Habilitation services | \$15 copayment / visit(s) | Not Covered | Limited to services to maintain/improve skills or functioning at risk due to medical deficits |
| | Skilled nursing care | No charge | Not Covered | Up to 100 days / benefit period |
| | 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 | No charge | 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.)

- | | | |
|---------------------|------------------|-----------------------|
| • Chiropractic care | • Dental | • Private Duty Nurses |
| • Cosmetic Surgery | • Long term care | • Weight loss program |
| • | • | |

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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)
- Hearing aid(s)
- Routine eye care
- Bariatric surgery
- Infertility
- 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 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

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 at <http://www.insurance.ca.gov/> or 1-800-927-HELP.

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

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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, kwüjigo holne' 1-800-278-3296.

—————*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 \$7,380
- Patient pays \$160

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 | \$10 |
| Coinsurance | \$0 |
| Limits or exclusions | \$150 |
| Total | \$160 |

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,970
- Patient pays \$430

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 | \$350 |
| Coinsurance | \$0 |
| Limits or exclusions | \$80 |
| Total | \$430 |

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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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