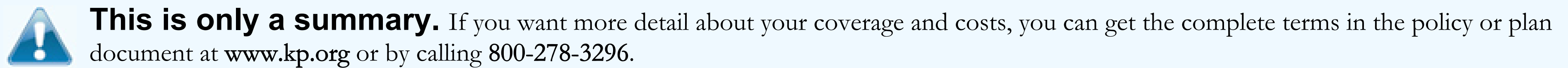
Kaiser Permanente: DEDUCTIBLE PLAN

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

Coverage Period: 10/01/2012-09/30/2013

Coverage for: Family | **Plan Type:** DHMO



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?	$1,000 person / $2,000 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 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. $3,000 person / $6,000 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 6. See your policy or plan document for additional information about excluded services.

- 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	$20 copayment/visit	Not Covered	Not subject to plan deductible.
	Specialist visit	$20 copayment/visit	Not Covered	Services related to Infertility covered at 50% coinsurance/visit. Not subject to plan deductible.
	Other practitioner office visit	$10 copayment/visit for chiropractic services,$20 copayment/visit for acupuncture.	Not Covered	Up to 30 visit(s) / Calendar Year for chiropractic services, Physician referred acupuncture. Chiro & Acupuncture Not subject to plan deductible.
	Preventive care/screening/immunization	$0 copayment/visit	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share. Not subject to plan deductible.
If you have a test	Diagnostic test (x-ray, blood work)	$10 copayment/ encounter	Not Covered	Not subject to plan deductible.
	Imaging (CT/PET scans, MRIs)	$50 copayment/ procedure	Not Covered	Not subject to plan deductible.

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	Retail:$10 copayment/ 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	Retail: $20 copayment/prescription for 31 to 60 day(s) ,$30 copayment/ prescription for 61 to 100 day(s). Certain drugs may be covered at a higher cost share. Not subject to plan deductible.
	Preferred brand drugs	Retail:$30 copayment/ 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	Retail: $60 copayment/prescription for 31 to 60 day(s) ,$90 copayment/ prescription for 61 to 100 day(s). Certain drugs may be covered at a higher cost share. Not subject to plan deductible.
	Non-preferred brand drugs	$30 copayment/ prescription for 1 to 30 day(s)	Not Covered	Same as Preferred brand drug when approved through exception process.
	Specialty drugs	$30 copayment/ prescription for 1 to 30 day(s)	Not Covered	Same as Preferred brand drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance/ procedure	Not Covered	——————none——————
	Physician/surgeon fees	20% coinsurance/ procedure	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 immediate medical attention	Emergency room services	20% coinsurance/ visit	20% coinsurance/ visit	——————none——————
	Emergency medical transportation	$150 copayment/trip	$150 copayment/trip	Not subject to plan deductible.
	Urgent care	$20 copayment/visit	$20 copayment/visit	Non plan providers covered when outside a service area. Not subject to plan deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance/ admission	Not Covered	——————none——————
	Physician/surgeon fee	20% coinsurance/ admission	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copayment/visit Individual, $10 copayment/visit Group	Not Covered	Not subject to plan deductible.
	Mental/Behavioral health inpatient services	20% coinsurance/ admission	Not Covered	——————none——————
	Substance use disorder outpatient services	$20 copayment/visit Individual, $5 copayment/visit Group	Not Covered	Not subject to plan deductible.
	Substance use disorder inpatient services	20% coinsurance/ 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. Not subject to plan deductible.
	Delivery and all inpatient services	20% coinsurance/ admission	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 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. Not subject to plan deductible.
	Rehabilitation services	Inpatient:20% coinsurance/ admission; Outpatient:$20 copayment/day	Not Covered	Inpatient:None; Outpatient:Not subject to plan deductible.
	Habilitation services	$20 copayment/day	Not Covered	Limited to services to maintain/ improve skills or functioning at risk due to medical deficits. Not subject to plan deductible.
	Skilled nursing care	20% coinsurance/ admission	Not Covered	Up to 100 day maximum per benefit period. Not subject to plan deductible.
	Durable medical equipment	20% coinsurance/ item	Not Covered	Must be in accordance with formulary guidelines. Not subject to plan deductible.
	Hospice service	$0 copayment/ service	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less. Not subject to plan deductible.
If your child needs dental or eye care	Eye exam	$0 copayment/visit	Not Covered	Not subject to plan deductible.
	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 • Routine Hearing Tests

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
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 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

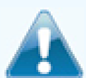
CHINESE: 若有問題：請撥打 1-800-757-7585 或 TTY/TDD 1-800-777-1370

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** $5,040
- **Patient pays** $2,500

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	$1,000
Co-pays	$200
Co-insurance	$1,100
Limits or exclusions	$200
Total	$2,500

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
Total	$5,400

Patient Pays:

Deductibles	$0
Co-pays	$800
Co-insurance	$200
Limits or exclusions	$80
Total	$1,080

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.