

KAISER PERMANENTE.: City & Co. of Broomfield DHMO 500 Coverage Period: 01/01/2013 - 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Subscriber + 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 1-855-249-5005 or TTY 1-800-521-4874.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 Individual / \$1,500 Family; Does not apply to preventive care services, services with copays and prescription drugs.	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, \$1,500 Individual / \$3,000 Family	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</u> <u>limit?</u>	Premiums, balanced-billed charges, health care this plan doesn't cover, and deductible	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> <u>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</u> of <u>providers</u> ?	Yes, see www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874) for a list of plan providers.	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?	No	You can see the specialist you choose without permission from this plan.
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 1-855-249-5005 (TTY 1-800-521-4874) 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 www.dol.gov/ebsa/pdf/SBCUniform Glossary.pdf or call 1-855-249-5005 (TTY 1-800-521-4874) to request a Page 1 of 8 copy.



- 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 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
	Primary care visit to treat an injury or illness	\$20 copay each visit (10% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the deductible.
If you visit a health care provider's office or clinic	Specialist visit	\$40 copay each visit (10% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the deductible.
	Other practitioner office visit	Not covered	Not covered	none
	Preventive care/ screening/immunization	No charge	Not covered	Not subject to the deductible.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray, 10% coinsurance; Lab, No charge	Not covered	10% coinsurance for x-ray and laboratory services in the outpatient department of a plan hospital
	Imaging (CT/PET scans, MRIs)	10% coinsurance	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
	Generic drugs	\$15/retail prescription; \$30/mail order prescription	Not covered	Copay not subject to the "overall" deductible. Infertility drugs not covered.
If you need drugs to treat your illness or condition	Brand drugs	\$30/retail prescription; \$60/mail order prescription	Not covered	Not subject to the "overall" deductible. Infertility drugs not covered.
More information about prescription drug coverage is available at www.kp.org/formulary	Non-preferred drugs	Not covered	Not covered	Except those prescribed and authorized through the non-preferred drug process. Not subject to the "overall" deductible. Infertility drugs not covered.
	Specialty drugs	20% coinsurance up to \$250 per drug dispensed	Not covered	Not subject to the "overall" deductible. Infertility drugs not covered.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	none
surgery	Physician/surgeon fees	10% coinsurance	Not covered	none
	Emergency room services	10% coinsurance	10% coinsurance	none
If you need immediate medical attention	Emergency medical transportation	10% coinsurance up to \$500 per trip	10% coinsurance up to \$500 per trip	Not subject to the deductible.
incurcar attention	Urgent care	\$40 copay each visit (10% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the deductible.
If you have a hospital	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	none
stay	Physician/surgeon fee	10% coinsurance	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
	Mental/Behavioral health outpatient services	\$20 copay each visit (10% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the deductible.
If you have mental health, behavioral	Mental/Behavioral health inpatient services	10% coinsurance	Not covered	none
health, or substance abuse needs	Substance use disorder outpatient services	\$20 copay each visit (10% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the deductible.
	Substance use disorder inpatient services	10% coinsurance	Not covered	none
If you are pregnant	Prenatal and postnatal care	\$0 copay each visit (10% coinsurance for covered services received during a visit)	Not covered	none
	Delivery and all inpatient services	10% coinsurance	Not covered	none
	Home health care	10% coinsurance	Not covered	Limited to 28 hours per week
If you need help	Rehabilitation services	\$20 copay each visit for out-patient services; See Facility fee under "If you have a hospital stay" for inpatient services.	Not covered	Outpatient visits limited to 20 visits per therapy per year; In-patient in a multi-disciplinary facility limited to 60 days per condition per year.
recovering or have	Habilitation services	Not covered	Not covered	none
other special health	Skilled nursing care	10% coinsurance	Not covered	Limited to 100 days per year
needs	Durable medical equipment	10% coinsurance	Not covered	\$2,000 annual maximum; Not subject to the deductible. Prosthetic arms and legs not subject to the annual maximum.
	Hospice service	10% coinsurance	Not covered	none
If your child needs dental or eye care	Eye exam	\$20 copay each visit (10% coinsurance for covered services received during a visit)	Not covered	For services with an ophthalmologist see "Specialist visit"; Copay not subject to the 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.)			
Acupuncture	• Glasses	 Non-emergency care when traveling outside the U.S. 	
•	Habilitation services	Private-duty nursing	
Chiropractic care	Hearing Aids	Routine foot care	
Cosmetic surgery	Infertility treatment	Weight loss programs	
Dental care (Adult)	• Long-term care	•	

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.)		
•	•	•
Bariatric surgery	Hearing Aids (Children under the age of 18)	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 1-855-249-5005 or TTY 1-800-521-4874. 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 <u>appeal</u> or file a <u>grievance</u>. For questions about your rights, this notice, or assistance, you can contact: The plan at 1-855-249-5005 or TTY 1-800-521-4874; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: <u>insurance@dora.state.co.us</u>.

Language Access Services:

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

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.

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Coverage Examples

Coverage for: Subscriber + Family | 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 vou 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 \$6,220.00
- Patient pays \$1,320.00

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

\$500.00
\$20.00
\$600.00
\$200.00
\$1,320

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

Amount owed to providers: \$5,400

- Plan pays \$4,220.00
- Patient pays \$1,180.00

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:

\$0.00
\$800.00
\$300.00
\$80.00
\$1,180

Total amounts above are based on subscriber only coverage.



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Coverage Examples

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 **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 <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 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-ofpocket 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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