KAISER PERMANENTE. **: EUTF Standard - KP Group Plan**

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

Coverage Period: 07/01/2014 - 06/30/2015

Coverage for: Individual / 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 **432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands)**.

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. $2500 person/$7500 family (3 or more members)	The out-of-pocket limit is the most you could pay during a calendar year (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, balance-billed charges and health care this plan doesn't cover.	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 1-808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor islands)	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 approval is required to see most 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 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands), TTY/TDD 1-877-447-5990 or visit us at www.kp.org.

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 1-808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) 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** s *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, ou 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	$20/visit	Not Covered	---none---
	Specialist Visit	$20/visit	Not Covered	---none---
	Other practitioner office visit	Not Covered	Not Covered	---none---
	Preventive care /screening/ immunization	No Charge/primary care visit No charge for immunizations	Not Covered	---none--- ---none---
If you have a test	Diagnostic test (x-ray, blood work)	Xray: $10/day (basic, outpt), Lab: $10/day (basic, outpt)	Not Covered	Xray: 20% coinsurance (special, outpt), Lab: 20% coinsurance (special, outpt)
	Imaging (CT/PET scans, MRIs)	CT/MRI: 20% coinsurance (Outpatient), PET: 20% coinsurance (Outpatient)	Not Covered	CT/MRI: Inpatient fee included in hospital stay, PET: Inpatient fee included in hospital stay

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 retail $20 mail order/prescription	Not Covered	$5/maintenance generic otc; Up to 30-day supply retail or 90-day supply mail; no charge contraceptives per
	Preferred brand drugs	$35 retail $70 mail order/prescription	Not Covered	$5/maintenance generic otc; Up to 30-day supply retail or 90-day supply mail; no charge contraceptives per
	Non-preferred brand drugs	$35 retail $70 mail order/prescription	Not Covered	$5/maintenance generic otc; Up to 30-day supply retail or 90-day supply mail; no charge contraceptives per
	Specialty drugs	$35 retail $70 mail order/prescription	Not Covered	$5/maintenance generic otc; Up to 30-day supply retail or 90-day supply mail; no charge contraceptives per
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Not Covered	---none---
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$100/visit		Must notify KP within 48 hours if admitted to a non plan provider; Limited to initial emergency only
	Emergency medical transportation	20% coinsurance		---none---
	Urgent care	$20/visit, 20% coinsurance (out of area)		---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	ot Covered	---none---
	Physician / surgeon fee		ot 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	$20/visit	Not Covered	---none---
	Mental/Behavioral health inpatient services	15% coinsurance	Not Covered	---none---
	Substance use disorder outpatient services	$20/visit	Not Covered	---none---
	Substance use disorder inpatient services	15% coinsurance	Not Covered	---none---
If you are pregnant	Prenatal and postnatal care	No Charge/confirmed pregnancy	Not Covered	---none---
	Delivery and all inpatient services	Delivery: 15% coinsurance. Limited to routine care.	Not Covered	15% coinsurance, newborn inpatient
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Physician visit covered at primary care visit copay
	Rehabilitation services	15% coinsurance, $20/visit (outpatient)	Not Covered	---none---
	Habilitation services	Not Covered	Not Covered	---none---
	Skilled nursing care	15% coinsurance	Not Covered	Limited to 60 days/benefit period
	Durable medical equipment	50% coinsurance diabetes equipment	Not Covered	50% coinsurance for all other equipment
	Hospice Service	No Charge	Not Covered	Includes two 90-day periods, followed by unlimited number of 60-day periods
If your child needs dental or eye care	Eye exam	$20/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.)	
• Acupuncture • Chiropractic care • Cosmetic Surgery • Dental • Glasses • Habilitation Services • Hearing aids	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • eight 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.)	
• Bariatric surgery • Infertility treatment • 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 Kaiser Permanente at 1-808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands). 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: Customer Service at 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands) or online at http://www.kp.org/memberservices.

Additionally, you may contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the State of Hawaii Department of Commerce and Consumer Affairs at : Hawaii Insurance Division Health Insurance Branch PO Box 3614 Honolulu, HI 96811 or call 1-808-586-2804 for the Hawaii Insurance Division of the Department of Commerce and Consumer Affairs.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

----------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 plan

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** $7,220
- **Patient pays** $320

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
accines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$100
Limits or exclusions	$200
Total	$320

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

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	$600
Coinsurance	$600
Limits or exclusions	$80
Total	$1,280

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

Total amounts above are based on subscriber only coverage.

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 al o help you ee what expen e 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.

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