KAISER PERMANENTE®: Clackamas County

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest

Coverage Period: January 1, 2015-December 31, 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** TRAD

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 **503-813-2000** or **1-800-813-2000**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting 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. **$600** Individual / **$1,200** 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, prescription drug charges, 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. See **www.kp.org** or call **503-813-2000 or 1-800-813-2000** for a list of participating 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?	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 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 **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 per visit	Not covered	If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Specialist visit	$10 per visit	Not covered	If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Other practitioner office visit	$10 per visit for physician-referred alternative care	Not covered	Acupuncture is limited to 12 visits per calendar year. Prior authorization required. If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	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	Some services may require prior authorization.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating 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	$10 per prescription at KP pharmacy/ $20 per prescription mail order	Not covered	Up to 30-day supply (retail); 31-90-day supply (mail order). No charge for contraceptives (subject to formulary guidelines).
	Preferred brand drugs	$20 per prescription at KP pharmacy/ $40 per prescription mail order	Not covered	
	Non-preferred brand drugs	$20 per prescription at KP pharmacy/ $40 per prescription mail order	Not covered	Covered only when you meet formulary exception criteria.
	Specialty drugs	$20 per prescription at KP pharmacy/ $40 per prescription mail order	Not covered	KP Formulary applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 per visit	Not covered	——————none——————
	Physician/surgeon fees	Included in facility fee	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$75 per visit		This cost sharing does not apply if admitted directly to the hospital as an inpatient for covered services (see "If you have a hospital stay" for inpatient cost sharing).
	Emergency medical transportation	$75 per trip		——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	$10 per visit		Non-participating provider urgent care covered only if you are temporarily outside of our service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Prior authorization required.
	Physician/surgeon fee	Included in facility fee	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Individual: $10 per visit/ Group: $5 per visit	Not covered	If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Mental/Behavioral health inpatient services	No charge	Not covered	Prior authorization required.
	Substance use disorder outpatient services	Individual: $10 per visit/ Group: $5 per visit	Not covered	If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Substance use disorder inpatient services	No charge	Not covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. If you receive services in addition to an office visit, additional copayments or coinsurance may apply.
	Delivery and all inpatient services	No charge	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to 130 visits per year. Prior authorization required.
	Rehabilitation services	Outpatient: $10 per visit/ Inpatient: No charge	Not covered	Coverage is limited to 20 visits per therapy per year. Prior authorization required.
	Habilitation services			Coverage is limited to neurodevelopmental disorders of early childhood. Rehabilitation limits apply. Prior authorization required.
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days per year. Prior authorization required.
	Durable medical equipment	No charge	Not covered	Coverage is limited to items on our DME formulary. Prior authorization required.
	Hospice service	No charge	Not covered	Prior authorization required.
If your child needs dental or eye care	Eye exam	$10 per visit	Not covered	For members age 18 and younger.
	Glasses	No charge for one pair standard frames and lenses or 6-month supply contact lenses every 24 months.	Not covered	For members age 18 and younger.
	Dental check-up	Not covered	Not covered	No coverage for dental checkup.

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.)			
• Dental care • Long-term care • Weight loss programs	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing	• Cosmetic surgery • Routine foot care
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your cost for these services.)			
• Acupuncture (self-referred) • Hearing aids (Adult)	• Bariatric surgery • Hearing aids (Age 18 and younger)	• Chiropractic care (self-referred) • Infertility treatment	• Glasses (Age 19 and older) • Routine eye care (Age 19 and older)

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 503-813-2000 or 1-800-813-2000. 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 503-813-2000 or 1-800-813-2000, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally a consumer assistance program can help you file your appeal. Contact the Oregon Insurance Division, P.O. Box 14480, Salem, OR 97309-0405, 503-947-7984, http://www.cbs.state.or.us/ins/index.html, or cp.ins@state.or.us.

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 1-800-324-8010.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-324-8010.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码): 1-800-324-8010.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-324-8010.

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
Copays	$20
Coinsurance	$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 $4,620**
- **Patient pays $780**

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	$700
Coinsurance	$0
Limits or exclusions	$80
Total	**$780**

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**, **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.