

Kaiser Permanente

Low Option

Summary of Benefits and Coverage

Kaiser Permanente: TRADITIONAL PLAN



Coverage Period: 01/01/2014-12/31/2014

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

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 1-800-278-3296.

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. \$1,500 Individual/\$3,000 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, 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 <i>specific</i> 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 1-800-278-3296.	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, 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 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-278-3296 or 1-800-777-1370 (TTY), 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 1-800-278-3296 or 1-800-777-1370 (TTY) to request a copy.

LOS ANGELES MACHINIST BENEFIT TRUST

PID:101980 CNTR:2 EU:20 Plan ID:1187 SBC ID:92784



- **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	\$25 per visit	Not Covered	—————none—————
	Specialist visit	\$25 per visit	Not Covered	Services related to infertility covered at \$25 per visit.
	Other practitioner office visit	\$25 per visit for acupuncture services.	Not Covered	Chiropractic care not covered. Physician referred acupuncture.
	Preventive care/ screening/ immunization	\$25 per visit	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No Charge; Lab tests: No Charge	Not Covered	—————none—————
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	—————none—————



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 per prescription for 1 to 100 days	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	\$30 per prescription for 1 to 100 days	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$25 per procedure	Not Covered	_____none_____
	Physician/surgeon fees	No Charge	Not Covered	_____none_____
If you need immediate medical attention	Emergency room services	\$100 per visit	\$100 per visit	_____none_____
	Emergency medical transportation	No Charge	No Charge	_____none_____
	Urgent care	\$25 per visit	\$25 per visit	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 per admission	Not Covered	_____none_____
	Physician/surgeon fee	No Charge	Not 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	\$25 per individual visit; \$12 per group visit	Not Covered	_____none_____
	Mental/Behavioral health inpatient services	\$100 per admission	Not Covered	_____none_____
	Substance use disorder outpatient services	\$25 per individual visit; \$5 per group visit	Not Covered	_____none_____
	Substance use disorder inpatient services	\$100 per admission	Not Covered	_____none_____
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge; Postnatal care: No Charge	Prenatal care: Not covered; Postnatal care: Not covered	Prenatal: Cost sharing is for routine preventive care only; Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	\$100 per admission	Not Covered	_____none_____
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per calendar year.
	Rehabilitation services	Inpatient: \$100 per admission; Outpatient: \$25 per day	Not Covered	_____none_____
	Habilitation services	\$25 per day	Not Covered	_____none_____
	Skilled nursing care	No Charge	Not Covered	Up to 100 days maximum per benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.



Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If your child needs dental or eye care	Eye exam	\$25 per visit	Not Covered	_____none_____
	Glasses	Not Covered	Not Covered	_____none_____
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

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.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Chiropractic care • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care unless medically necessary • 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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Acupuncture (plan provider referred) • Bariatric surgery | <ul style="list-style-type: none"> • Infertility treatment | <ul style="list-style-type: none"> • 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 1-800-278-3296. 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 the 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 1-800-927-HELP (4357) or www.insurance.ca.gov.

If this coverage is not subject to ERISA, you may also contact the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

Additionally, this consumer assistance program can help you file your appeal:

Department of Managed Health Care Help Center	1-888-466-2219
980 9th Street, Suite 500	www.healthhelp.ca.gov
Sacramento, CA 95814	helpline@dmhc.ca.gov

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 1-800-788-0616 or TTY/TDD 1-800-777-1370

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 or TTY/TDD 1-800-777-1370

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-757-7585 or TTY/TDD 1-800-777-1370

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 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.
