KAISER PERMANENTE. **STATE OF MARYLAND**   **Coverage Period: 01/01/2015 – 12/31/2015**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs   **Coverage for:** Members | **Plan Type:** MD IHM SIG

⚠ **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 my.kp.org/maryland or by calling 1-855-839-5763.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> 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 <u>out–of–pocket limit</u> on my expenses?	Yes. **$1,500** person/**$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 <u>out–of–pocket limit</u>?	Premiums, balance-billed charges (unless balance-billing is prohibited), 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 <u>network</u> of <u>providers</u>?	Yes. For a list of plan providers, go to **my.kp.org/maryland** or call 855-839-5763.	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 <u>specialist</u>?	Yes.	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 1-855-839-5763, TTY/TDD 711 or visit us at my.kp.org/maryland.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at   **1 of 8**
www.dol.gov/ebsa/healthreform or call 855-249-5018 to request a copy.
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> ⚠️
> - **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	$15/visit	Not covered	Waived for children under age 5
	Specialist visit	$15/visit	Not covered	——————none——————
	Other practitioner office visit	Acupuncture: $15/visit; Chiropractic Care: $15/visit	Not covered	Acupuncture for chronic pain management only. Preauthorization required
	Preventive care/screening/immunization	No charge	Not covered	Age & frequency schedule may apply
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	——————none——————

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KAISER PERMANENTE **STATE OF MARYLAND**   **Coverage Period: 01/01/2015 – 12/31/2015**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs   **Coverage for:** Members | **Plan Type:** MD IHM SIG

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 http://dbm.maryland.gov/benefits	Generic drugs	Not covered	Not covered	Outpatient prescription drug coverage is not included in the Kaiser Permanente medical plan. Prescription drug coverage is offered as a separate plan by your employer
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	—————none—————
	Physician/surgeon fees	No charge	Not covered	—————none—————
If you need immediate medical attention	Emergency room services	$150/visit	$150/visit	Waived if admitted as inpatient
	Emergency medical transportation	No charge	No charge	—————none—————
	Urgent care	$15/visit	$15/visit	Non-plan providers are covered only outside the service area
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Emergency admissions covered for non-plan providers
	Physician/surgeon fee	No charge	Not covered	Emergency services covered for non-plan providers

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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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Individual: $15/visit; Group: $7/visit	Not covered	No coverage for psychological and neuropsychological testing for ability, aptitude, intelligence, or interest
	Mental/Behavioral health inpatient services	No charge	Not covered	——————none——————
	Substance use disorder outpatient services	Individual: $15/visit; Group: $7/visit	Not covered	——————none——————
	Substance use disorder inpatient services	No charge	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy
	Delivery and all inpatient services	No charge	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 120 days/year
	Rehabilitation services	Inpatient: No charge; Outpatient: $15/day	Not covered	Outpatient: Limited to 50 days/year combined for Physical, Occupational, and Speech Therapy
	Habilitation services	Inpatient: No charge; Outpatient: $15/visit	Not covered	For children under age 19 with a congenital or genetic birth defect
	Skilled nursing care	No charge	Not covered	Limited to 180 days/year
	Durable medical equipment	No charge	Not covered	——————none——————
	Hospice service	No charge	Not covered	——————none——————

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KAISER PERMANENTE. **STATE OF MARYLAND**   **Coverage Period: 01/01/2015 – 12/31/2015**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs   **Coverage for:** Members | **Plan Type:** MD IHM SIG

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 your child needs dental or eye care More information on dental coverage is available at http://dbm.maryland.gov /benefits	Eye exam (non routine)	$15/visit	Not covered	——————none——————
	Glasses	No charge	Not covered	For children up to age 19, vision hardware from a select group of frames and lenses is covered at 100%. For vision hardware not included in the select group, member pays cost above the allowed amount provided by the State of Maryland
	Dental check-up	Not covered	Not covered	Dental check-ups are not included in the Kaiser Permanente medical plan. Dental coverage is offered as a separate plan by your employer

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 <u>excluded services</u>.)

- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine foot 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (1 per ear per 36 months)
- Infertility treatment
- Routine eye care (Adult)
- Weight loss programs

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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 1-855-839-5763. 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, contact the plan at 1-855-839-5763. You may contact your state insurance department, or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the State's Health Education and Advocacy Unit of the Consumer Protection Division Maryland Office of the Attorney General, Health Education and Advocacy Unit at 1-877-261-8807 or www.oag.state.md.us/Consumer.HEAU.htm.

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 855-839-5763 or TTY/TDD 711

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-839-5763 or TTY/TDD 711

CHINESE: 若有問題：請撥打855-839-5763 或 TTY/TDD 711

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-839-5763 or TTY/TDD 711

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

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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** $7,340
- **Patient pays** $200

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	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$200**

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

- **Amount owed to providers: $5,400**
- **Plan pays** $2,300
- **Patient pays** $3,100

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	$200
Coinsurance	$0
Limits or exclusions	$2,900
Total	**$3,100**

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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.

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