



Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

Kaiser Permanente for Small Businesses Evidence of Coverage for SAMPLE GROUP AGREEMENT GRP SMALL NONM - PLAN 1637 PLAN 30- N; OPT

\$30 Copayment Plan
Group ID: 999999901 EOC Number: 4

Note: This is a sample Evidence of Coverage (EOC) document. EOCs that are issued as part of a specific customer's Group Agreement will differ from this sample. For example, this EOC does not include customer-specific coverage and eligibility information, and the sample EOC may be updated at any time for accuracy, to comply with laws and regulations, or to reflect changes in how coverage is administered. The terms of any contract holder's coverage are governed by the Group Agreement issued to that customer by Kaiser Foundation Health Plan, Inc.

Highlights

Deductible for certain drugs..... \$250 per calendar year

Copayments and Coinsurance

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|---|--|
| Most consultations, exams, and treatment..... | \$30 per visit |
| Hospital inpatient care..... | \$400 per day |
| Outpatient surgery..... | \$200 per procedure |
| Emergency Department visits..... | \$100 per visit |
| Most generic drugs..... | \$10 for up to a 100-day supply |
| Most brand-name drugs..... | \$35 for up to a 100-day supply after \$250 Deductible for certain drugs |

January 1, 2012, through December 31, 2012

Pending regulatory approval

Member Service Call Center
Weekdays 7 a.m.–7 p.m.; weekends 7 a.m.–3 p.m.
(except holidays)
1-800-464-4000 toll free
1-800-777-1370 (toll free TTY for the hearing/speech impaired)
kp.org

- ◆ cholesterol tests (lipid panel and profile)
- ◆ diabetes screening (fasting blood glucose tests)
- ◆ fecal occult blood tests
- ◆ HIV tests
- ◆ prostate specific antigen tests
- ◆ certain sexually transmitted disease (STD) tests

Outpatient Care

We cover the following outpatient care subject to the Cost Sharing indicated:

- Primary and specialty care consultations, exams, and treatment (other than those described below in this "Outpatient Care" section): **a \$30 Copayment per visit**
- Preventive Care Services:
 - ◆ routine physical maintenance exams, including well-woman exams: **no charge**
 - ◆ well-child preventive exams for Members through age 23 months: **no charge**
 - ◆ family planning counseling, or consultations to obtain internally implanted time-release contraceptives or intrauterine devices (IUDs) prescribed in accord with our drug formulary guidelines: **no charge**
 - ◆ after confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **no charge**
 - ◆ alcohol and substance abuse screenings: **no charge**
 - ◆ developmental screenings to diagnose and assess potential developmental delays: **no charge**
 - ◆ immunizations (including the vaccine) administered to you in a Plan Medical Office: **no charge**
 - ◆ flexible sigmoidoscopies: **no charge**
 - ◆ screening colonoscopies: **no charge**
- Allergy injections (including allergy serum): **a \$5 Copayment per visit**
- Outpatient surgery: **a \$200 Copayment per procedure** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery is covered at **a \$30 Copayment per procedure**
- Outpatient procedures (other than surgery): **a \$200 Copayment per procedure** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Benefits and Cost Sharing" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")
- Voluntary termination of pregnancy: **a \$30 Copayment per procedure**
- Physical, occupational, and speech therapy: **a \$30 Copayment per visit**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **a \$30 Copayment per day**
- Urgent Care consultations, exams, and treatment: **a \$30 Copayment per visit**
- Emergency Department visits: **a \$100 Copayment per visit**. The Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient for covered Services, or if you are admitted for observation and are then admitted directly to the hospital as an inpatient for covered Services (for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section). However, the Emergency Department Copayment does apply if you are admitted for observation but are not admitted as an inpatient
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- **Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): a \$30 Copayment per visit**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge**
- Some types of outpatient consultations, exams, and treatment may be available as group appointments, which we cover at **a \$15 Copayment per visit**