City of San José – Retirement Services

# KAISER PERMANENTE PLAN COMPARISON

(California Only)

| SERVICE: | DEDUCTIBLE HMO (DHMO) PLAN<br>1-800-464-4000<br>Group #887 (NCal)<br>Group# 230179 (SCal)<br>www.kaiserpermanente.org | $25 CO-PAY PLAN<br>1-800-464-4000<br>Group #887 (NCal)<br>Group# 230179 (SCal)<br>www.kaiserpermanente.org | SENIOR ADVANTAGE (KPSA)<br>1-800-464-4000<br>Group #887 (NCal)<br>Group# 230179 (SCal)<br>www.kaiserpermanente.org |
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| **GENERAL PLAN INFORMATION** | Kaiser is a prepaid group practice Health Maintenance Organization (HMO), which provides direct services through Kaiser Foundation hospitals, medical offices and physicians ONLY. Kaiser members are encouraged to choose a personal physician from the staff for themselves and for each eligible family member.<br><br>**Kaiser offers coverage in the Hawaii and Northwest regions. The rates and coverage levels are different to those of the California region. Call Retirement Services at (408) 794-1000 (press #3) or visit our website www.sjretirement.com for details.** | | |
| **WHO IS ELIGIBLE?** | Retirees (who are not Medicare-eligible) who reside in the Kaiser Service Area, and eligible dependents.<br><br>*The following services are limited for members who live outside of the Kaiser Service Area: Home Health Care, Skilled Nursing Facility, Hospice care, Durable Medical Equipment, and Hearing Aids. | Retirees (who are not Medicare-eligible) who reside in the Kaiser Service Area, and eligible dependents.<br><br>*The following services are limited for members who live outside of the Kaiser Service Area: Home Health Care, Skilled Nursing Facility, Hospice care, Durable Medical Equipment, and Hearing Aids. | Retirees who are 65+ and eligible for Medicare Parts A & B or Part B only, MUST reside in the Kaiser service area. Kaiser's service areas are based on zip code and county. Please contact Kaiser at the 800 number above to determine if you live a Senior Advantage service area.<br><br>**Effective 11/1/2008, CMS is not allowing KPSA members to have double coverage.** |
| **ELIGIBLE FAMILY MEMBERS** | • Spouse<br>• Domestic Partner (Registered with the State).<br>• Dependent children, including children of domestic partners, step-children, foster children or children under the employee's legal guardianship, up to age 26.<br>• Unmarried children incapable of self-sustaining employment because of mental or physical disability who were enrolled at the time they became disabled; or at age 19 if disability occurred prior to age 19. Kaiser requires certification of disability for coverage. Ongoing certification is required.<br>• Per the provision of the Obama Healthcare Reform, dependent adult children between the ages of 19 and 26 may continue the medical coverage. There is no need to submit proof of full time student status. | | |
| **CONTINUATION OF BENEFITS** | **For all plans:**<br>Participants who lose coverage under the subscribing member have the right to continue coverage under COBRA legislation. Eligible COBRA participants are required to pay the entire premium each month, plus a two percent (2%) administration fee. COBRA eligible participants must apply to continue coverage within 60 days of loss of coverage. | | |
| **COMMON TERMS** | **<u>Out-of-pocket maximum</u>:** The maximum amount you will pay for certain covered services in a calendar year. Once you have reached the maximum, you will not have to pay any deductibles, co-pays, or coinsurances for most covered services for the rest of the calendar year. Not all services apply toward the annual out-of-pocket maximum like prescriptions, durable medical equipment, and infertility services.<br><br>**Coinsurance:** The percentage of charges you pay when receiving certain covered services. For example, 30 percent coinsurance for hospitalization means you pay 30 percent of the charges for covered hospital services. Coinsurance, which varies depending on your plan, doesn't apply toward your deductible. But it does count toward your annual out-of-pocket maximum.<br><br>**Copayment (or co-pay):** The fixed amount you pay when you receive certain covered services or prescriptions. For example, a $25 office visit co-pay means you pay $25 for each office visit. Copayments, which vary depending on your plan, do not apply toward your deductible. But they do count toward your annual out-of-pocket maximum.<br><br>**Deductible:** The set amount you need to pay in a calendar year before Kaiser or Blue Shield will provide most covered services at a co-pay or coinsurance. Not all services may count toward the deductible. | | |
| **COORDINATION OF BENEFITS** | Contact Kaiser for details | Contact Kaiser for details | Contact Kaiser for details |

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| **TOOLS FOR HEALTHY LIVING** | Programs and information available on-line for total health assessment, weight management and physical fitness, stress reduction, good nutrition, smoking cessation, diabetes, depression, and insomnia.<br><br>Kaiser members (non-Medicare) may participate in HealthMedia Healthy Lifestyle Program Rewards. This is an interactive on-line program which provides health and fitness tools and gives cash rewards for participation. www.kp.org/healthylifestyles | | |
| **LIFETIME MAXIMUM** | None | None | None |
| **ANNUAL DEDUCTIBLE** | $1,500 per individual<br>$3,000 per family | None | None |
| **CALENDAR YEAR CO-PAY MAX** | | | |
| **Single** | $4,000/yr | $1,500/yr. | $1,500/yr |
| **1 Member in Family** | $4,000/yr | $1,500/yr. | $1,500/yr. |
| **Family** | $8,000/yr | $3,000/yr. | $3,000/yr |
| | The annual deductible and all coinsurance/copayments for services throughout the year will apply to the Out of Pocket maximum, excluding those for:<br>• Prescription Drugs<br>• Durable Medical Equipment<br>• Hearing Aids<br>• Infertility Services | The copayments for services throughout the year will apply to the Out of Pocket maximum, excluding those for:<br>• Prescription Drugs<br>• Durable Medical Equipment<br>• Hearing Aids<br>• Infertility Services | The copayments for services throughout the year will apply to the Out of Pocket maximum, excluding those for:<br>• Prescription Drugs<br>• Durable Medical Equipment<br>• Hearing Aids<br>• Infertility Services |
| **PHYSICIAN OFFICE VISITS:** | **$40** co-pay per visit; Deductible doesn't apply | **$25** co-pay per visit | **$25** co-pay per visit |
| **PRESCRIPTIONS** | **$10** (generic)/**$30** (brand) co-pay per prescription for up to 30-day supply when deemed medically necessary, prescribed by a Plan physician, and obtained at Plan pharmacies<br><br>Mail Order: **$20** (generic)/**$60** (brand) co-pay per prescription for up to 100-day supply when deemed medically necessary, prescribed by a Plan physician, and obtained through Plan mail order.<br><br>Subject to formulary | **$10** Generic (30-day supply)<br>**$25** Brand (30-day supply)<br><br>Mail order for 100-day supply:<br>**$20** Generic<br>**$50** Brand<br><br>Prescriptions at Kaiser pharmacy as prescribed (subject to formulary). | **$10**/prescription for 100-day supply at Kaiser pharmacy for generic or brand name drugs as prescribed (subject to formulary).<br><br>Mail order available |

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| **ALCOHOLISM AND DRUG ADDICTION** | Inpatient: **30%** co-insurance per admittance, after Deductible, for detoxification in Kaiser Permanente-approved facility only; no day limit<br><br>Transitional Residential Recovery Services (TRRS): **$100** co-pay per admittance, after Deductible, at an approved facility.<br><br>Outpatient: **$40** (individual)/$5 (group) co-pay per visit (Deductible doesn't apply); no visit limit | Inpatient: **$100** for detoxification in Kaiser-approved facility only<br><br>Transitional Residential Recovery Services (TRRS): **$100** per admission for up to 60 days per calendar year, not to exceed 120 days in any 5 consecutive years at an approved facility.<br><br>Outpatient: **$25** co-pay per visit; no limit to visits. | Inpatient **$250**/admission for detoxification in Kaiser-approved facility only<br><br>Transitional Residential Recovery Services (TRRS): **$100/**admission for up to 60 days per calendar year, not to exceed 120 days in any 5 consecutive years at an approved facility.<br><br>Outpatient: **$25**/visit |
| **ALLERGY TESTS AND TREATMENT** | Tests: **$40** co-pay/visit; Deductible doesn't apply<br><br>Treatment: **No charge, after Deductible**, for allergy injections (includes allergy serum) | **$25** co-pay per office visit<br><br>**$5** co-pay for allergy injections | **No charge**; no limit to visits |
| **AMBULANCE** | **$150** co-pay per trip when determined to meet the criteria that define an emergency | **No charge** when authorized by Kaiser. | **$50** co-pay per trip |
| **CHIROPRACTIC & ACUPUNCTURE** | Chiropractic: Not covered<br>Acupuncture: **$40** co-pay per visit (Deductible doesn't apply) when deemed medically necessary and prescribed by a Plan physician. Covered as alternative to standard treatment as determined by a Plan physician; primarily a component of a multidisciplinary chronic pain management program. | Chiropractic: Not covered<br>Acupuncture: **$25** co-pay per visit when deemed medically necessary and prescribed by a Plan physician. Covered as alternative to standard treatment as determined by a Plan physician; primarily a component of a multidisciplinary chronic pain management program. | Chiropractic: **$20** co-pay per visit<br>Acupuncture: **$25** co-pay per visit when deemed medically necessary and prescribed by a Plan physician. Covered as alternative to standard treatment as determined by a Plan physician; primarily a component of a multidisciplinary chronic pain management program. |

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| **CONTINUING CARE** | Home Health: **No charge** per visit (Deductible doesn't apply) when prescribed by a Kaiser Permanente physician. Employees living outside Kaiser Permanente's Service Area may receive services at a friend or family member's home within the Service Area.<br><br>Skilled Nursing Facility: **30%** co-insurance per admittance, after Deductible, up to 100 days per benefit period. Employees living outside Kaiser Permanente's Service Area may receive services from a contracted vendor inside the Service Area.<br><br>Hospice: **No charge** (Deductible doesn't apply) when selected as an alternative to traditional in-hospital services. Retirees living outside Kaiser's Service Area may receive services at a contracted vendor inside the Service Area.<br><br>All continuing care coverage requires prior authorization. | Home Health: **No charge** when prescribed by a Kaiser physician. Members living outside of the Kaiser service area may receive services at a friend or family member's home within the service area.<br><br>Skilled Nursing Facility: **No charge**, up to 100 days per calendar year. Members living outside of the service area may receive services from a contracted vendor inside the service area.<br><br>Hospice: **No charge** when selected as an alternative to traditional in-hospital services. Retirees living outside of the service area may receive services from a contracted vendor inside the service area.<br><br>All continuing care coverage requires prior authorization. | Home Health: **No charge** when prescribed by a Kaiser physician<br><br>Skilled Nursing Facility: **No charge**, up to 100 days per benefit period<br><br>Hospice: **No charge** when selected as an alternative to traditional in-hospital services<br><br>All continuing care coverage requires prior authorization. |
| **DURABLE MEDICAL EQUIPMENT** | **20%** co-insurance per item (Deductible doesn't apply) when deemed medically necessary and prescribed by a Plan physician in accordance with DME formulary guidelines.<br><br>Retirees who live outside of Kaiser's Service Area may pick up items such as canes, crutches, and diabetic supplies within the Service Area. Most DME items must be delivered and maintained within the Service Area. This may be at a friend or family member's home within the Service Area, but the item must remain within the Service Area. | Covered 100% according to formulary guideline<br><br>Retirees who live outside of Kaiser's Service Area may pick up items such as canes, crutches, and diabetic supplies within the Service Area. Most DME items must be delivered and maintained within the Service Area. This may be at a friend or family member's home within the Service Area, but the item must remain within the Service Area. | **20%** Coinsurance according to formulary guidelines |
| **EMERGENCY ROOM** | **30%** co-insurance, after Deductible, covered worldwide<br><br>Co-pay is waived if admitted directly to the hospital as an inpatient.<br><br>Emergency room visits must be coordinated through Kaiser Permanente if not at a Kaiser Permanente facility as soon as reasonably possible. | **$100** co-pay worldwide coverage<br><br>Co-pays are waived if admitted directly to the hospital as an inpatient.<br><br>Emergency room visits must be coordinated through Kaiser if not at a Kaiser facility as soon as reasonably possible. | **$50** co-pay per visit<br><br>Co-pays are waived if admitted directly to the hospital as an inpatient.<br><br>Emergency room visits must be coordinated through Kaiser if not at a Kaiser facility as soon as reasonably possible. |

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| **HEARING AIDS** | **$500** allowance per device, limited to 2 devices every 36 months (limited to 1 device per ear), when medically necessary<br><br>Retirees who live outside of Kaiser Permanente's Service Area may obtain Hearing Aids from a contracted vendor inside the Service Area. | Covered up to **$500** per device every 36 months when medically necessary<br><br>Retirees who live outside of Kaiser Permanente's Service Area may obtain Hearing Aids from a contracted vendor inside the Service Area. | Covered up to **$500** per device every 36 months when medically necessary |
| **HOSPITAL ROOM & EXTRAS** | **30%** coinsurance per admittance, after deductible | **$100** per admittance Physician services, room & board, tests, medications, supplies, therapies | **$250** per admittance Physician services, room & board, tests, medications, supplies, therapies |
| **INFERTILITY SERVICES** | **50%** co-insurance (Deductible doesn't apply) | **50%** infertility benefit | Inpatient: **$250**/admission<br><br>Outpatient: **$25** co-pay per visit |
| **MENTAL HEALTH SERVICES AND PSYCHOTHERAPY** | Inpatient: **30%** co-insurance per admittance, after Deductible; no day limit<br><br>Outpatient: **$40** (individual)/**$20** (group) co-pay per visit; Deductible doesn't apply; no visit limit | Inpatient: **$100** co-pay per admittance<br><br>Outpatient:**$25** (individual)/**$12** (group) co-pay per visit; no visit limit | Inpatient: **$250**/admission<br><br>Outpatient: **$25** (individual)/**$12** (group) co-pay per visit; no visit limit |
| **NON-NETWORK & OUT-OF-AREA COVERAGE** | Worldwide coverage for medically necessary emergency services due to unforeseen illness. Limited to emergency services required before the member's condition permits transfer or travel to the nearest Kaiser facility. Member must notify health plan of hospitalization as soon as is reasonably possible (when clinically stable). Follow-up care is not covered. | Full coverage for emergency and urgent care for Medically necessary services.<br><br>Prior authorization for services required before member's medical condition permits travel or transfer to nearest Kaiser Permanente facility for care. | Covers Emergency and Urgent Care for Medically Necessary Services.<br><br>Prior Authorization for Emergency and Urgent Care Services is required before member's medical condition permits travel or transfer to nearest Kaiser facility for care. |
| **OUTPATIENT SURGERY** | Member pays **30%** coinsurance after Deductible | $100 per procedure. | |
| **OUTPATIENT X-RAY AND LABORATORY** | Preventive: **No charge** (Deductible doesn't apply)<br><br>Diagnostic**:** **$10** co-pay per encounter, after Deductible.<br><br>**$50** co-pay per procedure, after Deductible, for MRI, most CT and PET scans | **No charge**; no limit to number of visits with physician referral<br><br>**$25** co-pay for MRI/CT/PET Scans | **No charge**; no limit to number of visits with physician referral<br><br>**No Charge** for MRI/CT/PET Scans |

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*Effective 1/1/2013*

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| **PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY** | Inpatient: See Hospital Services section<br>Outpatient: **$40** co-pay per visit after Deductible | Inpatient: See Hospital Services section<br>Outpatient: **$25** co-pay per visit after Deductible | **$25** co-pay |
| **PROSTHETICS/ ORTHOTICS** | **No charge** (Deductible doesn't apply) when deemed medically necessary and prescribed by a Plan physician | **No charge** when deemed medically necessary and prescribed by a Plan physician | **No Charge** internally implemented. **20%** co-insurance for external devices |
| **ROUTINE PHYSICALS** (According to schedule) | **No charge** for Preventive routine physical exam (Deductible doesn't apply) | **No charge** for Preventive routine physical exams | **No charge** for Preventive routine physical exams |
| **SURGEONS, ASSISTANTS, ANESTHETISTS** | Included in **30%** co-insurance per admittance, after Deductible | **No charge** | |
| **VISION** | **No charge** Eye exams for refraction (Deductible doesn't apply) | **No charge** Routine preventive refraction exam | **$25** co-pay for exams<br>**$150** frame allowance every 24 months. |
| **WELL BABY CARE & IMMUNIZATIONS** | **No charge** (Deductible doesn't apply) | **No charge** | **No charge** |
| **WOMEN'S HEALTH AND MATERNITY** | Women's Health – Preventive: **No charge** per visit (Deductible doesn't apply); Diagnostic: **$40** co-pay per visit (Deductible doesn't apply).<br>Maternity – Preventive care exams and first post-partum follow-up consultation and exam: No charge (Deductible doesn't apply). Delivery: **30%** co-insurance after Deductible | **No charge** for complete care to member for office visits<br>**$100** co-pay per admittance for physician and hospital services | **No charge** for Annual Wellness Visits<br>**$5**/visit for scheduled prenatal care exams<br>**$250** co-pay for delivery |