Kaiser Foundation Health Plan of the Northwest
Oregon Region

IMPORTANT DETAILS AND NOTICES

Kaiser Permanente Individuals and Families Plans

1-800-494-5314
buykp.org/apply

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

60036330

KAISER PERMANENTE®

500 NE Multnomah St., Suite 100
Portland, OR 97232

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Have a question? We're here to help. Call **1-800-494-5314**,
8 a.m. to 8 p.m., Monday–Friday; 9 a.m. to 5 p.m., Saturday.

Important details and notices

Choosing a health care provider is one of the most important decisions you'll ever make, so you'll want to make sure you're well informed. This brochure features detailed information on our Individuals and Families plans so you can be confident you're choosing the best plan for you and your family.

The following is a summary of the Kaiser Permanente Individuals and Families Plans general exclusions and limitations. (See your contract for a detailed list of benefit specific exclusions and limitations.)

Exclusions and limitations

The following are not covered or have limited coverage:

- Services related to noncovered services, except services otherwise covered if they are to treat complications which arise from the noncovered services.
- Acupuncture, chiropractic services, massage therapy, and naturopathy services are limited to when a participating provider makes a referral in accord with medical group criteria.
- Physical exams and other services required to obtain or maintain employment or to participate in employee programs; insurance or governmental licensing; on a court order or required for parole or probation; or while incarcerated.
- Services provided or arranged by criminal justice officials or institutions for detained or confined individuals is limited to services which meet the requirements of emergency care under the *Member Agreement*.
- Cosmetic care services that are intended primarily to change or maintain your appearance and that will not result in significant improvement in physical function. This exclusion does not apply to reconstructive surgery services.
- Custodial care services for assistance with activities of daily living or care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.
- Dental services, except medically necessary for members who have a medical condition that a participating provider determines would place the member at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by a participating physician.
- Collection, processing, and storage of blood donated by donors whom the member designates, and procurement and storage of cord blood are covered only when medically necessary for the imminent use at the time of collection for a designated recipient.
- Durable medical equipment, orthopedic shoes or appliances, and medical supplies, except for the following: diabetic supplies; equipment furnished and billed as part of covered inpatient hospital, home health, or hospice services; certain maxillofacial prosthetic devices; medically necessary prosthetics and orthotics; and post-mastectomy prostheses and bras.
- We do not reimburse the employer for any services that the law requires an employer to provide.
- Experimental or investigational services.
- Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.
- Services provided by a member of your immediate family.
- Genetic testing and related services are limited to genetic counseling and medically appropriate genetic testing for the purpose of diagnostic testing to determine disease and/or predisposition of disease and to develop treatment plans. Covered services are limited to preconception and prenatal testing for detection of congenital and heritable disorders, and testing for the prediction of high-risk occurrence or reoccurrence of disease when medically necessary as determined by a participating physician, in accordance with applicable law. However, testing for family members who are not members is always excluded.

- We do not reimburse the government agency for services that the law requires be provided only by or received from a government agency. This exclusion does not apply to Medicaid.
- Hearing aids tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid.
- Hypnotherapy and all related services.
- Services for diagnosis and treatment of infertility, including reversal of voluntary, surgically induced infertility; the cost of donor semen, donor eggs, and services related to their procurement and storage.
- All services for conception by artificial means including, but not limited, to prescription drugs, donor semen, and donor eggs related to these services. This exclusion includes, but is not limited to, artificial insemination, in vitro fertilization, ovum transplants, and gamete (GIFT) and zygote (ZIFT) intrafallopian transfers.
- Services that are not medically necessary.
- Nonreusable medical supplies are limited to those supplied and applied by a licensed health care provider, while providing a covered service.
- Sexual reassignment surgery.
- Temporomandibular joint disorders (TMJ) services.
- Supportive care primarily to maintain the level of correction already achieved; care primarily for the convenience of the member; and care on a non-acute, symptomatic basis.
- Corrective lenses, eyeglasses, and contact lenses, including contact lenses fitting and follow-up care, unless a "Vision Hardware Optical Services Rider" is attached to the agreement.
- Vision therapy, orthoptics, or eye exercises.
- Low-vision aids.
- Bariatric surgery, gastric stapling, gastric bypass, gastric bands, switch duodenal, biliopancreatic division, weight loss programs, counseling, and any other services for weight control, even if the purpose of the services is to treat other medical conditions related to, caused by, or complicated by obesity.

Disclosure statement

Nongroup disclosure statement for members without Medicare benefits

This notice describes plans for Kaiser Permanente for Individuals and Families. For specific plan information, see the following forms: for traditional copayment plans, *WOIdTrad0110, BsOIdPlat0110, BsOIdPlatRx0110, ROIdRxGU0110, ROIdPlatVHY0110*; for deductible plans, *WOIdDed0110, BsOIdDed5000110, BsOIdDed10000110, BsOIdDed15000110, BsOIdDed25000110, BsOIdDed35000110, BsOIdDed50000110, BsOIdDed75000110, ROIdDRxGU0110, BsOIdDedB15000110, BsOIdDedB25000110, BsOIdDedB35000110, BsOIdDedB50000110, BsOIdDedB75000110*; for child only deductible plans, *BsOIdCO50000110, BsOIdCO75000110, ROIdCORxGU0110*; for high deductible health plans, *WOIdHDHP0110, BsOIdHDHP15000110, BsOIdHDHP26000110*. To obtain a *Member Agreement* for a particular plan, contact Membership Services.

Notice

This disclosure statement addresses health plan coverage and costs. It is intended for your use if you are purchasing a health plan for the first time or replacing or adding to existing coverage. Please note that this statement is not intended to be part of the *Member Agreement* and that only the language of the *Member Agreement* issued by Kaiser Foundation Health Plan of the Northwest (KFHPNW) is final and binding.

Read your *Member Agreement*

If you purchase the offered plan, read the *Member Agreement* carefully as soon as you receive it. As a purchaser of an individual plan, you have the opportunity to reconsider your decision and may request a premium refund. Fill out your application completely and truthfully. If misstatements are made or information about your health is omitted from the application, KFHPNW may void the *Member Agreement* or deny your claims. If your age is misstated, the contract may be rescinded or the premium will be adjusted to reflect the correct premium for your age.

Are you considering replacing your current coverage?

Before you replace your current plan, you should review both agreements to determine if replacement is in your best interest. The new coverage may be different in important respects. You should be aware of these differences and whether they are temporary or permanent. If you obtained your current plan from another producer or a representative of another company, be sure to ask that producer or representative any questions you may have about that plan.

Are you considering adding to your current coverage?

Before you add new coverage to your current coverage, you should review both agreements to make sure you are not buying unnecessary coverage. If you obtained your current

plan from another producer or a representative of another company, be sure to ask that producer or representative any questions you may have about that plan and the need for additional coverage. If you have questions that are not answered by this disclosure statement, be sure to ask your producer or insurance representative.

Whom to call

For more information about benefits, please refer to your *Member Agreement*, *Benefit Summary*, vision rider, and prescription drug rider (if included). If you have questions, you may visit our Membership Services desk at the facility nearest you or call Membership Services from 8 a.m. to 6 p.m., Monday through Friday. From Portland, call **503-813-2000**; from all other areas, call **1-800-813-2000**. The toll-free TTY line for the hearing and speech impaired, from all areas, is **1-800-735-2900**; for language interpretive services, from all areas, call **1-800-324-8010**.

Outline of coverage

Read the *Member Agreement* carefully

This outline of coverage provides a very brief description of the important features of the plan. Please note that this outline is not intended to be a part of the *Member Agreement*. Only the actual *Member Agreement* provisions are final and binding. The *Member Agreement* itself sets forth, in detail, your rights and obligations as well as those of KFHPNW.

Kaiser Permanente for Individuals and Families Plans expense coverage

Our plans are designed to provide a broad range of inpatient and outpatient coverage (care)—inpatient hospital, medical, and surgical services (care); X-ray and laboratory; prescription drugs (some plans); routine physical exams; and rehabilitation therapies—subject to any copayment and/or coinsurance provisions or other limitations that may be set forth in the *Member Agreement*.

Benefits

A brief description of the benefits—including copayments, coinsurance, and deductible; dollar amounts; and exclusions and limitations—is outlined in this kit.

Waiting periods for pre-existing conditions

This coverage has a six-month waiting period for pre-existing conditions. This means that we do not pay for services received by you or your enrolled dependent(s) for pre-existing conditions for the first six months you or your dependents are enrolled in this plan. A pre-existing condition is any medical condition, illness, or injury for which medical advice, diagnosis, care, or treatment was recommended or received, or for which a prudent person would have sought advice or treatment, within the six-month period immediately before coverage began. This waiting period does not apply to prenatal care, newborns, adopted children, and medical foods and formulas necessary for the treatment of phenylketonuria (PKU).

In addition, we will not pay for services or supplies during the first six months a member is enrolled for expenses incurred for the following conditions:

- Allergies and their symptoms, including asthma
- Elective procedures that we determine can be reasonably postponed until the end of the waiting period, including but not limited to sterilization, tonsillectomies, and adenoidectomies
- Mental disorders

In certain circumstances, we will waive or reduce this waiting period based on current or prior creditable coverage.

Emergency benefits

In an emergency, call 911 or go to the nearest emergency facility. Emergency care is for emergency medical conditions. Emergency medical conditions are conditions in which the immediate onset of acute symptoms are of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or fetus in the case of a pregnant woman, in serious jeopardy.

Prescription drug coverage (applies only to plans with prescription option)

If your plan includes coverage for outpatient prescription drugs (as outlined in the *Choose a Plan* brochure), you must use our pharmacies to fill prescriptions written by participating providers or licensed dentists. For most refills, try our mail-delivery pharmacy service. It's fast and convenient. For details, check your *Medical Directory* or ask at your pharmacy.

What you pay

Please refer to your plan's benefit description in the *Choose a Plan* brochure for copayment and coinsurance for covered prescriptions. If you do not use our pharmacy or if your prescription is not written by a participating provider or licensed dentist, you will pay 100 percent of the full charge.

The formulary process

Our drug formulary includes the list of drugs reviewed and approved by the Regional Formulary and Therapeutics Committee. To find out if a particular drug is included on the formulary, call our Formulary Application Services Team (FAST) at **503-261-7900** or toll free at **888-572-7231**. The Regional Formulary and Therapeutics Committee chooses drugs for the formulary based on a number of factors, including safety and effectiveness as determined from a review of scientific literature. For most members, formulary drugs are appropriate treatment. However, when a participating provider feels that a nonformulary drug is medically necessary to meet a patient's individual medical needs, the provider may request an exception. Criteria for exceptions include the following:

- The nonformulary drug is required by law to bear the legend "Rx only."
- We determine the drug meets all other coverage requirements except that our formulary does not list it for your condition.
- A participating or designated physician has determined the patient has experienced treatment failure with or is allergic to or intolerant of the alternatives listed in the formulary.
- Your condition meets any additional requirements that the Regional Formulary and Therapeutics Committee has approved for the drug, supply, or supplement.

If the exception is approved, you pay the same charge as for a formulary drug.

Utilization review

Utilization review is the formal method we use to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of specific health care services, procedures, or settings. Certain treatments and services are subject to utilization review based on criteria developed by Northwest Permanente P.C., Physicians and Surgeons (KFHPNW's medical group), and/or other organizations utilized by the medical group and approved by KFHPNW.

For more information about utilization review or a written explanation of our utilization review criteria for a particular condition, contact Membership Services.

Prior authorization

Most care at participating facilities does not require prior authorization (advance approval) if it's received from a participating provider. However, certain services do require prior or concurrent authorization in order to be covered. A service must also be covered by your health plan in order for you to receive the benefit.

Services that require prior or concurrent authorization include, but are not limited to:

- Breast reduction surgery
- Inpatient hospital services
- Hospice and home health care services
- Non-emergency medical transportation
- Open MRI
- Drug formulary exceptions
- Plastic or reconstructive surgery
- Referrals for nonparticipating providers' services
- Rehabilitative therapy services
- Routine foot care
- Skilled nursing facility services
- Transplants

Your participating provider will request prior or concurrent authorization when necessary. If a treatment or service you believe you need is not authorized, you'll receive a written explanation of the reason, your right to appeal the decision, and the appeal process.

Keeping your records private

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers and facilities to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, we may share your PHI with employers only with your authorization or as otherwise permitted by law.

We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices*. Giving us this authorization is at your discretion.

Have a question? We're here to help. Call **1-800-494-5314**, 8 a.m. to 8 p.m., Monday–Friday; 9 a.m. to 5 p.m., Saturday.

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This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Membership Services. Our *Notice of Privacy Practices* is also available at **kp.org**.

Access to your PHI

To review your medical record, contact:

Health Information Management
Regional Process Center
10220 SE Sunnyside Road
Clackamas, OR 97015

For completion of medical/insurance reports or for copies of medical records, call **503-571-5051**, 7:30 a.m. to 4:30 p.m., Monday through Friday.

To obtain emergency medical record information, call **503-571-5815**, 24 hours a day.

If you think part of your record is incorrect, you may ask to add a statement amending the record.

For more information, contact Membership Services.

If you think your personal health information was shared without your prior permission, contact Member Relations at **503-813-4480** (from Portland) or **1-800-813-2000** (from all other areas).

Participating providers and participating facilities compensation

Participating providers and participating facilities may be paid in various ways. These include salary, per diem rates, case rates, fee-for-service, incentive payments, and capitation payments.

Capitation payments are based on the total number of members (on a per-member per-month basis), regardless of the amount of services provided. Company may directly or indirectly make capitation payments to participating providers and participating facilities only for the professional services they deliver, and not for services provided by other physicians, hospitals, or facilities. To learn more about the ways participating providers and participating facilities are paid to provide or arrange medical and hospital care for Kaiser Foundation Health Plan of the Northwest members, please call Membership Services.

Our contracts with participating providers and participating facilities provide that you are not liable for any amounts we owe. However, you will be liable for the cost of noncovered services that you receive from a participating provider or participating facility, as well as unauthorized services you obtain from nonparticipating providers and nonparticipating facilities.

Membership Services

If you have questions or need help, call Membership Services. We're available by telephone 8 a.m. to 6 p.m., Monday through Friday.

Portland **503-813-2000**
All other areas **1-800-813-2000**
TTY **1-800-735-2900**
Language interpretation services **1-800-324-8010**

Or log onto **kp.org** and e-mail Membership Services.

CHOOSE
GOOD HEALTH

Visit **buykp.org/apply**
Or call **1-800-494-5314**

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