

# HOW COPAYMENT PLANS WORK



Copayment plans are the simplest to use and to understand. **No services are subject to a deductible.**

With copayment plans, you pay set charges (or copayments) for certain covered services so you know your out-of-pocket costs for doctor's visits, prescriptions, etc., in advance. And since you don't have to meet a deductible, you're eligible to pay copayments from the first day of coverage.

## USING OUR COPAYMENT PLAN

Let's say you injure your ankle and visit your primary care participating provider, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

On the KP 0/25/Rx plan, you would pay a separate copayment (or copay) for each of the covered services you received. In this case, you would pay a \$25 copay for the doctor's office visit, a \$25 copay for the X-ray, and a \$15 copay for the generic drug.

No surprises. No deductible.

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# BENEFIT HIGHLIGHTS

## PLATINUM COPAYMENT PLAN

### KP 0/25/RX

#### FEATURES

Deductible	None
Out-of-pocket maximum	\$5,000

#### BENEFITS

##### PREVENTIVE CARE

Many preventive care services, such as routine physical exams and mammogram screenings, are no charge from the first day of coverage.

##### OUTPATIENT SERVICES (per visit or procedure)

Primary care office visit	\$25 copay
Specialty office visit	\$35 copay
Nurse treatment visit (includes allergy injections) <sup>1</sup>	\$20 copay
Outpatient surgery <sup>2</sup>	\$250 copay
Lab tests and X-ray <sup>2</sup>	\$25 copay
MRI, PET, CT	\$100 copay

##### INPATIENT HOSPITAL CARE

Inpatient care (including maternity)	\$500 copay per day
Maximum per admittance	\$2,500

##### MATERNITY COVERAGE (outpatient)

Prenatal care (applies to prenatal office visits, one postnatal visit, and lactation consultations)	No charge
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##### EMERGENCY AND URGENT CARE

Emergency room visit (waived if admitted)	\$250 copay
Urgent care visit	\$45 copay
Ambulance service	\$250 per trip

##### PRESCRIPTION DRUGS

(up to a 30-day supply) <sup>3</sup>	\$15 or 50% (whichever is greater)
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##### OTHER

Vision exams	\$25 copay
Vision hardware allowance (applies to lenses, frames, and/or contacts every 24 months)	\$150 allowance
Dental plans	Optional coverage available. See the "Dental Plans" section.

This brochure provides summaries of various plans and is not a contract. Plan details are provided in the *Evidence of Coverage*. To obtain an *Evidence of Coverage* for a particular plan, contact Membership Services.

<sup>1</sup>Waived if in conjunction with an office visit

<sup>2</sup>Preventive tests and procedures are no charge.

<sup>3</sup>Prescribed contraceptives are no charge.

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# HOW DEDUCTIBLE PLANS WORK



Deductible plans generally offer lower monthly premiums in exchange for higher out-of-pocket payments for covered services.

With these plans, you pay full charge for most covered services until your expenses meet an annual deductible. Then, for covered services, you pay a coinsurance.

## DEDUCTIBLES

Under a deductible plan, many covered services are subject to the **deductible**—the **set amount** for which you pay full charge in a calendar year.

This means you'll pay full charge for certain medical services until you reach your annual deductible.

## NO DEDUCTIBLE FOR MANY SERVICES

With our deductible plans, many services, such as primary care office visits and urgent care, are available for a copayment before you meet your deductible.

And to encourage you to receive preventive care, many services are available for no charge before you meet your deductible.

## OUT-OF-POCKET MAXIMUMS

The **out-of-pocket maximum** is the **maximum amount** you have to pay out of pocket for certain covered services in a calendar year. If you meet your out-of-pocket maximum, you will not be required to pay anything for certain covered services for the remainder of the year.

In our deductible plans, the deductible does not apply toward the out-of-pocket maximum. You must first meet your deductible and then meet your out-of-pocket maximum.

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# USING A DEDUCTIBLE PLAN

Let's say you injure your ankle and visit your primary care physician, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

On the KP 500/25/Rx plan, you have to pay \$500 out of pocket before you are eligible to pay a copayment or coinsurance for most covered services.

In this example, even if you have not met your deductible, you would only pay a \$25 copayment (or copay) for the doctor's office visit and a \$25 copay for the X-ray, because these services are not subject to the deductible under this plan. For the generic drug, you would pay either a \$15 copay or a 50 percent coinsurance (whichever is greater). This service is also not subject to a deductible.

Visit the treatment fee tool at [kp.org/treatmentestimates](https://kp.org/treatmentestimates) to estimate the cost of your next appointment or your potential out-of-pocket medical costs for the year.

## THE HSA DIFFERENCE

Some of our deductible plans are HSA-qualified deductible plans. These plans can be paired with an optional health savings account, or HSA. HSA-qualified plans work similarly to traditional deductible plans with just a few differences:

- If you're eligible, you can open an HSA with an HSA-qualified plan.
- Money you deposit into your HSA is deductible from your federal income tax.
- You can use funds from your HSA to pay for qualified medical expenses.
- In traditional deductible plans, the deductible **does not apply** to the out-of-pocket maximum. In HSA-qualified deductible plans, the deductible **does apply** to the out-of-pocket maximum.
- In traditional deductible plans with family coverage, each family member needs to meet his or her individual deductible and out-of-pocket maximum.
- In HSA-qualified plans with family coverage, there are no individual deductibles or out-of-pocket maximums. The family must meet family deductibles or out-of-pocket maximums.

Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser. To learn more about health savings accounts, visit [www.irs.gov/publications/p969/ar02.html](https://www.irs.gov/publications/p969/ar02.html).

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# BENEFIT HIGHLIGHTS

	GOLD DEDUCTIBLE PLANS	
	KP 500/25/Rx	KP 1000/25/Rx
FEATURES		
Deductible (individual)	\$500	\$1,000
Out-of-pocket maximum (individual)	\$5,000	
BENEFITS		
Services not subject to deductible unless otherwise indicated		
PREVENTIVE CARE		
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge from the first day of coverage.		
OUTPATIENT SERVICES (per visit or procedure)		
Primary care office visit	\$25 copay	
Specialty office visit	\$35 copay	
Nurse treatment visit (includes allergy injections) <sup>1</sup>	\$20 copay	
Outpatient surgery <sup>2</sup>	\$150 copay (after deductible)	
Lab tests and X-ray <sup>2</sup>	\$25 copay	
MRI, PET, CT	20% coinsurance (after deductible)	
INPATIENT HOSPITAL CARE		
Inpatient care (including maternity)	20% coinsurance (after deductible)	
Maximum per admittance	None	
MATERNITY COVERAGE (outpatient)		
Prenatal care (applies to prenatal office visits, one postnatal visit, and lactation consultations)	No charge	
EMERGENCY AND URGENT CARE		
Emergency Department visit	20% coinsurance (after deductible)	
Urgent care visit	\$45 copay	
Ambulance service	20% coinsurance (after deductible)	
PRESCRIPTION DRUGS		
(up to a 30-day supply) <sup>3</sup>	\$15 or 50% (whichever is greater)	
OTHER		
Vision exams	\$25 copay	
Vision hardware allowance (applies to lenses, frames, and/or contacts every 24 months)	\$100 allowance	
Dental plans	Optional coverage available. See the "Dental Plans" section.	

This brochure provides summaries of various plans and is not a contract. Plan details are provided in the *Evidence of Coverage*. To obtain an *Evidence of Coverage* for a particular plan, contact Membership Services.

<sup>1</sup>Waived if in conjunction with an office visit

<sup>2</sup>Preventive procedures and tests are no charge and not subject to deductible.

<sup>3</sup>Prescribed contraceptives are no charge.

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# BENEFIT HIGHLIGHTS

	SILVER DEDUCTIBLE PLANS			BRONZE DEDUCTIBLE PLANS	
	KP 1500/30/Rx	KP 2500/30/Rx	KP 3500/30/Rx	KP 5000/35	KP 7500/35
FEATURES					
Deductible (individual)	\$1,500	\$2,500	\$3,500	\$5,000	\$7,500
Out-of-pocket maximum (individual)	\$10,000			\$15,000	
BENEFITS					
Services not subject to deductible unless otherwise indicated					
PREVENTIVE CARE					
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge from the first day of coverage.					
OUTPATIENT SERVICES (per visit or procedure)					
Primary care office visit	\$30 copay			\$35 copay	
Specialty office visit	30% coinsurance (after deductible)			50% coinsurance (after deductible)	
Nurse treatment visit (includes allergy injections) <sup>1</sup>					
Outpatient surgery <sup>2</sup>					
Lab tests and X-ray <sup>2</sup>					
MRI, PET, CT					
INPATIENT HOSPITAL CARE					
Inpatient care (including maternity)	30% coinsurance (after deductible)			50% coinsurance (after deductible)	
Maximum per admittance	None			None	
MATERNITY COVERAGE (outpatient)					
Prenatal care (applies to prenatal office visits, one postnatal visit, and lactation consultations)	No charge			No charge	
EMERGENCY AND URGENT CARE					
Emergency Department visit	30% coinsurance (after deductible)			50% coinsurance (after deductible)	
Urgent care visit	\$50 copay			\$55 copay	
Ambulance service	30% coinsurance (after deductible)			50% coinsurance (after deductible)	
PRESCRIPTION DRUGS					
(up to a 30-day supply) <sup>3</sup>	\$15 or 50% (whichever is greater)			Not covered	
OTHER					
Vision exams	30% coinsurance			50% coinsurance	
Vision hardware allowance (applies to lenses, frames, and/or contacts every 24 months)	Not covered			Not covered	
Dental plans	Optional coverage available. See the "Dental Plans" section.				

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# HOW HSA-QUALIFIED DEDUCTIBLE PLANS WORK



An HSA-qualified deductible plan is a deductible plan that is eligible to be paired with an optional health savings account, or HSA. If you sign up for an HSA-qualified deductible plan and open an HSA, you can pay for qualified medical expenses with tax-deductible dollars.<sup>1</sup>

An HSA-qualified plan works much like a traditional deductible plan. You pay full charges for certain covered services out of pocket until you reach your deductible, and then you're eligible to pay coinsurance or copayments for covered services. The main difference is that you can save money with HSA-qualified plans. This is because you can pay for qualified medical expenses—even those not covered by your health plan—with tax-deductible dollars. However, qualified expenses not covered by your health plan will not contribute to your deductible or out-of-pocket maximum.

All you have to do is:

- Sign up for an HSA-qualified health plan.
- If you are eligible, open a health savings account.
- Contribute tax-deductible dollars to this account.<sup>2</sup>
- Use those tax-free funds to pay for qualified health care expenses.

What you don't use rolls over to the next year and continues earning interest.<sup>3</sup>

## ADVANTAGES OF OPENING AN HSA

- **Portability.** The money belongs to you, so if you change health plans, you can take your HSA with you.
- **Rollover of unused funds.** There is no "use it or lose it" restriction each year. What you don't use stays in your account until you are ready to use it.<sup>3</sup>
- **Control.** You decide when to put the money in and when to take it out.
- **Retirement savings.** The money in your account can be invested through the institution where you open it. And after age 65, you can use the funds, taxed at your ordinary income rate, for any reason without penalties.
- **Flexibility.** You can use the money in your HSA to pay for qualified medical expenses, even those your deductible plan does not cover.

<sup>1</sup>Tax references relate to federal income tax only. The tax treatment of health savings account contributions and distributions under state income tax laws differs from the federal tax treatment. Consult with your financial or tax adviser for more information.

<sup>2</sup>For 2012, the federally established maximum contribution for an eligible individual with self-only coverage is \$3,100. The annual maximum contribution for an eligible individual with family coverage is \$6,250. This annual maximum is indexed annually for inflation. Tax savings refer to federal income tax only. For more information, please consult your financial or tax adviser.

<sup>3</sup>Earnings vary depending on the type of investment plan you opt for and/or the HSA provider you choose. Amount earned is based on the investment plan and market value, and in some instances, the account may actually lose money.

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# USING A HEALTH SAVINGS ACCOUNT

## WHAT ARE QUALIFIED MEDICAL EXPENSES?

You can use an HSA to pay for deductibles, copays, coinsurance, and many supplies and services not covered by your health plan. Generally, these are expenses that would qualify for the medical and dental expense deduction on your income tax.

Here are just a few examples of HSA-qualified expenses:

- Eyeglasses and laser eye surgery
- Dental care
- Acupuncture
- Chiropractic services
- Hearing aids

For a complete list, see *Publication 502, Medical and Dental Expenses* at [www.irs.gov](http://www.irs.gov).

## WHO'S ELIGIBLE FOR AN HSA?

To be eligible for an HSA, you need to meet the following requirements:

- You can't be enrolled in Medicare.
- You can't be eligible to be claimed as a dependent on someone else's tax return.
- You can't have additional health coverage that is not a qualified deductible plan (with certain exceptions).
- You can't have received benefits from the Department of Veterans Affairs in the past three months.

You may set up your HSA through any financial institution that offers these accounts.<sup>1</sup>

## AN HSA OFFERS TRIPLE TAX ADVANTAGES

- Tax-deductible contributions to your account
- Tax-free investment earnings
- Tax-free withdrawals when funds are used for qualified medical expenses

## USING AN HSA-QUALIFIED DEDUCTIBLE PLAN

Let's say you injure your ankle and visit your primary care participating provider, who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication.

With our HSA-qualified deductible plans, **all covered services other than preventive care are subject to your deductible**. On the KP 2000/20%/HSA/Rx plan, you would pay the first \$2,000 of your medical and pharmacy expenses out of pocket. Then you would be eligible to pay a 20 percent coinsurance for most covered services.

In this example, you would pay full charge for the doctor's office visit, the X-ray, and the medication. All your out-of-pocket costs for covered services would be applied to your \$2,000 deductible.

And, if you opened an HSA, you would be able to pay for these services with tax-free dollars. (Tax savings relate to federal income tax only. For more information, please consult your financial or tax adviser. For more information on health savings accounts, please visit [www.irs.gov/publications/p969/ar02.html](http://www.irs.gov/publications/p969/ar02.html).)

<sup>1</sup>Kaiser Foundation Health Plan of the Northwest does not provide or administer financial products, including HSAs, and does not offer financial, tax, or investment advice. Members are responsible for their own investment decisions. If a member uses his or her HSA debit card to pay for something other than a qualified medical expense, the expenditure is subject to tax and, for individuals who are not disabled or over 65, a 20 percent tax penalty. It is the member's responsibility to determine whether the expenses qualify for tax-free reimbursement from his or her HSA.

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# BENEFIT HIGHLIGHTS

	HSA-QUALIFIED PLANS	
	KP 2000/20%/HSA/Rx	KP 3000/20%/HSA
FEATURES		
Deductible	\$2,000 individual/\$4,000 family	\$3,000 individual/\$6,000 family
Out-of-pocket maximum	\$5,000 individual/\$10,000 family	
BENEFITS		
Services not subject to deductible unless otherwise indicated		
PREVENTIVE CARE		
Many preventive care services, such as routine physical exams and mammogram screenings, are no charge from the first day of coverage.		
OUTPATIENT SERVICES (per visit or procedure)		
Primary care office visit	20% coinsurance (after deductible)	
Specialty office visit		
Nurse treatment visit (includes allergy injections) <sup>1</sup>		
Outpatient surgery <sup>2</sup>		
Lab tests and X-ray <sup>2</sup>		
MRI, PET, CT		
INPATIENT HOSPITAL CARE		
Inpatient care (including maternity)	20% coinsurance (after deductible)	
Maximum per admittance	None	
MATERNITY COVERAGE (outpatient)		
Prenatal care (applies to prenatal office visits, one postnatal visit, and lactation consultations)	No charge	
EMERGENCY AND URGENT CARE		
Emergency Department visit	20% coinsurance (after deductible)	
Urgent care visit		
Ambulance service		
PRESCRIPTION DRUGS		
(up to a 30-day supply) <sup>3</sup>	\$15 or 50% (whichever is greater) (after deductible)	Not covered
OTHER		
Vision exams	20% coinsurance (after deductible)	
Vision hardware allowance (applies to lenses, frames, and/or contacts every 24 months)	Not covered	
Dental plans	Optional coverage available. See the "Dental Plans" section.	

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<sup>1</sup>Waived if in conjunction with an office visit

<sup>2</sup>Preventive procedures and tests are no charge and not subject to deductible.

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# 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 section features detailed information on our Individuals and Families plans so you can be confident you're choosing the best plan.

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.)

## MEDICAL 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 *Evidence of Coverage*.
- 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: breast pumps; 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

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# IMPORTANT DETAILS AND NOTICES

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- 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 are excluded for members 18 and older unless the member is under the student limiting age and is enrolled in an accredited education institution.
  - 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 *Evidence of Coverage*.
  - Vision therapy, orthoptics, or eye exercises.
  - Low-vision aids.
  - Bariatric surgery, gastric stapling, gastric bypass, gastric bands, switch duodenal, biliopancreatic division, weight loss programs, 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 brochure provides summaries of various plans and is not a contract. For specific plan information about the plans referred to in this brochure, see the following forms: for traditional copayment: *EOIDTRAD0112*, *RORXGU0112*, *ROIDVHY0112*, *ROIDVHI0112*, *FSOIDXX0112RNGF*, *BSOIDTRADXX0112*; for deductible plans: *EOIDDED0112*, *BSOIDDEDXX0112*, *RORXGU0112*, *ROIDVHI0112*, *FSOIDXX0112RNGF*; for HSA-qualified deductible plans (HDHP): *EOIDHDHP0112*, *BSOIDHDHPXX0112*, *FSOIDXX0112RNGF*, *RORXH80112*. Plan details are provided in the *Evidence of Coverage*. To obtain an *Evidence of Coverage* for a particular plan, contact Membership Services.

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# IMPORTANT DETAILS AND NOTICES

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## NOTICE

This disclosure statement addresses health plan coverage and deductibles, copayments, and coinsurance. 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 *Evidence of Coverage* and that only the language of the *Evidence of Coverage* issued by Kaiser Foundation Health Plan of the Northwest (KFHPNW) is final and binding.

## READ YOUR EVIDENCE OF COVERAGE

If you purchase the offered plan, read the *Evidence of Coverage* 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 *Evidence of Coverage* 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 the *Evidence of*

Coverage for each 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 *Evidence of Coverage*, *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 EVIDENCE OF COVERAGE 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 *Evidence of Coverage*. Only the actual *Evidence of Coverage* provisions are final and binding. The *Evidence of Coverage* itself sets forth, in detail, your rights and obligations as well as those of KFHPNW.

### KAISER PERMANENTE INDIVIDUALS AND FAMILIES PLANS 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 deductible, copayment, and/or coinsurance provisions or other limitations that may be set forth in the *Evidence of Coverage*.

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# IMPORTANT DETAILS AND NOTICES

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## 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 provide covered services to applicants age 19 and older for pre-existing conditions during the six months following the effective date of coverage. A *pre-existing condition* is any medical condition, illness, or injury within the six months prior to the effective date of coverage for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent person would have sought advice or treatment.

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 the *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 **1-888-572-7231**. 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.

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# IMPORTANT DETAILS AND NOTICES

(continued)

## 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 to protect your PHI. Your PHI is individually identifiable information about your health, health care services you receive, or payment for your health care. 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, health research, payment, and health care operations purposes, such as measuring the quality of

services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, member identifiable health information is shared with your 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.

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](http://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.

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# IMPORTANT DETAILS AND NOTICES

(continued)

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.

## DENTAL EXCLUSIONS AND LIMITATIONS

- Cosmetic services that are intended primarily to improve appearance, or to repair and/or replace cosmetic dental restorations.
- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning when provided in conjunction with dental implants; and services associated with postoperative conditions and complications arising from implants.
- Drugs obtainable with or without a prescription. If you have separate medical coverage, these may be covered under your medical coverage.
- Experimental or investigational treatments, procedures, and other services that are not commonly considered standard dental practice or that require United States (U.S.) Food and Drug Administration (FDA) approval. A service is experimental or investigational if:
  - the service is not recognized in accordance with generally accepted dental standards as safe and effective for use in treating the condition in question, whether or not the service is authorized by law for use in testing or other studies on human patients; or
  - the service requires approval by FDA authority prior to use and such approval has not been granted when the service is to be rendered.
- Full mouth reconstruction and occlusal rehabilitation, including appliances, restorations, and procedures needed to alter vertical dimension, occlusion, or correct attrition or abrasion.
- Genetic testing.
- Medical or hospital services.
- Myofunctional therapy.
- Missed appointment fees a provider may charge for a missed appointment.
- Prosthetic devices following extraction of a tooth (or teeth) for nonclinical reasons or when a tooth is restorable.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns.

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# IMPORTANT DETAILS AND NOTICES

(continued)

- Sedation and general anesthesia (such as intramuscular IV sedation, non-IV sedation, and inhalation sedation) except for nitrous oxide when administered by an oral surgeon, periodontist, or pediatric dentist pursuant to the nitrous oxide benefit.
- Services for conditions that are covered by workers' compensation or that are the employer's responsibility.
- Services provided or arranged by criminal justice institutions for members confined therein, unless care would be covered as emergency dental care.
- Services that the law requires be provided or reimbursed at or by a government agency.
- Speech aid prosthetic devices and follow-up modifications.
- Surgery to correct malocclusion or temporomandibular joint disorders; treatment for problems of the jaw joint, including temporomandibular joint syndrome and craniomandibular disorders; and treatment of conditions of the joint linking the jawbone and skull and of the complex of muscles, nerves, and other tissues related to that joint.

- Treatment of micrognathia.
- Treatment of macroglossia.
- Treatment to restore tooth structure lost due to attrition, erosion, or abrasion.

## LIMITATIONS

- Repair or replacement needed due to normal wear and tear of fixed and removable prosthetics appliances that are less than five years old.
- Works-in-progress started prior to your effective date are not covered and are the liability of the member or a prior dental insurance carrier. The only exception is a root canal in which the pulpal debridement has been completed. Dental services to complete the root canal following pulpal debridement will be covered.

## ORTHODONTIC SERVICES EXCLUSIONS

We do not cover services or supplies for any of the following:

- Replacement of broken appliances.
- Re-treatment of orthodontic cases.
- Changes in treatment necessitated by an accident.

- Maxillofacial surgery.
- Treatment of primary/transitional dentition.

This brochure provides summaries of various plans and is not a contract. Dental plan details are provided in the *Evidence of Coverage*. For specific plan information about the plans referred to in this flyer, see the following forms: EOIDDNTDEDXX0112 – *Evidence of Coverage*; BSOIDDNTDXX0112 – *Benefit of Summaries for Dental Plans*; FSOIDDNTDXX0112 – *Face Sheet Individuals and Families Dental Plans*. To obtain an *Evidence of Coverage* for a particular plan, contact Membership Services.

## 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 email Membership Services.

This brochure provides summaries of various plans and is not a contract. For specific plan information about the plans referred to in this brochure, see the following forms: for traditional copayment: EOIDTRAD0112, RORXGU0112, ROIDVHY0112, ROIDVHI0112, FSOIDXX0112RNGF, BSOIDTRADXX0112; for deductible plans: EOIDDED0112, BSOIDDEDXX0112, RORXGU0112, ROIDVHI0112, FSOIDXX0112RNGF; for HSA-qualified deductible plans (HDHP): EOIDHDHP0112, FOIDGRDXX0112, BSOIDHDHPXX0112, FSOIDXX0112RNGF, RORXH80112.

Plan details are provided in the *Evidence of Coverage*. To obtain an *Evidence of Coverage* for a particular plan, contact Membership Services.

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