



KAISER PERMANENTE **INDIVIDUAL & FAMILY PRODUCTS**

2008

# KAISER PERMANENTE INDIVIDUAL & FAMILY PRODUCTS

The trusted solution for your individual and family clients

## GIVE YOUR CLIENTS MORE

In a health care market that's constantly changing, you can count on Kaiser Permanente to provide dependable, high-quality care for your clients.

- **No other major plan has it**—Physicians, specialists, labs, and pharmacists working together to deliver seamless, cost-effective care—with no claims paperwork.
- **Resources to manage health**—First-rate preventive services, health education, and excellent medical care, including superior chronic conditions management.
- **Tools to manage health care**—Online, interactive tools empower members to e-mail their doctor's office, refill prescriptions, request routine appointments, and view after-visit summaries on [kp.org](http://kp.org) anytime.

- **Recognized high-quality care**—According to the 2007 California Cooperative Healthcare Reporting Initiative Report on Quality, Kaiser Permanente in Northern and Southern California received the highest score among health plans in 25 out of 37 clinical measures. The next closest plan received the highest score in 4 out of 37 measures.

In 2008, there are also more ways to demonstrate the value of Kaiser Permanente than ever before. There are new resources that can help you grow your business, including an online, customized marketing tool that helps you present our plans quickly and conveniently.

Earn an additional \$50 bonus for each enrolled member that you renew by January 1, 2008.

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# ONLINE SOLUTIONS

## GROUPTRAK—YOUR ONLINE SOURCE FOR CUSTOMIZABLE MARKETING

GroupTrak is a convenient online tool that helps you create your own marketing powerhouse—and it’s all at your fingertips. Just log on and choose from preapproved, customized direct-mail pieces. All you need to do is upload a mailing list and pay the fees—all online. Materials will print and mail on the date you specify. To get started, visit **kp.litorders.com** or call broker sales at **1-800-789-4661, option 6.**

## YOUR ONLINE LIBRARY IS WAITING

Visit **brokers.kp.org** and click on “Individual & family coverage” under the “Health plans” tab—you can access a wealth of printed materials and review different plans, print out enrollment materials, and your clients can even apply online. It’s your go-to source for details to inform your client conversations. You can:

- Fill out and submit an online application.
- View conversion plan highlights and rates.
- Print membership agreements for Northern and Southern California.
- Download plan information in English, Chinese, Korean, Spanish, and Vietnamese.
- Catch up on the latest broker news.





# ADDITIONAL SERVICES



## ANCILLARY SERVICES

### Optical discounts help your clients see more savings

Eye exams are included in our coverage for individuals and families—so your clients' eye care is connected to their primary care. Plus, all your individual and family clients will receive a **20 percent discount** on eyeglasses, sunglasses, and contact lenses from top designers like Gucci, Brooks Brothers, Fendi, and Calvin Klein! Visit [kp.org/2020](http://kp.org/2020) for promotions in your area.

### Dental plans

Offer your clients dental coverage through our partnership with Delta Dental, a provider who shares our philosophy of preventive care. Delta Dental is one of the nation's largest and most experienced dental benefits providers. Through Delta Dental's extended network, your clients have a wide choice of individual dentists throughout California.

## MY HEALTH MANAGER— REDEFINING THE HOUSE CALL

*My health manager* on [kp.org](http://kp.org) makes online care easier than ever. Your clients' employees will enjoy industry-leading online services:

- E-mail their doctor's office
- View test results
- Refill prescriptions
- Request routine appointments
- And more

Deliver maximum value to your clients by helping their employees avoid unnecessary office visits, save money on copays or coinsurance, and stay productive at work.

<sup>1</sup> Kaiser Permanente doesn't endorse any of the facilities, organizations, products, or supplies mentioned in this publication. Any trade names listed are for easy identification only.

# SCENARIOS<sup>2</sup>

## GETTING A HEALTHY START

A young family is preparing to send their oldest child to kindergarten while their youngest is just beginning to walk. This family could benefit from coverage with a set copayment and access to well-child services.

### Solutions:

- \$25 Copayment Plan
- \$50 Copayment Plan

Families who choose a copayment plan won't have to worry about surprise expenses at the doctor's office because primary and specialty care office visit copayments are predetermined. Preventive services such as flu shots and screenings help families maintain their health.

## FIT AND HEALTHY

A 25-year-old former college athlete has maintained her healthy lifestyle and rarely needs care. She wants coverage for major injuries and illnesses, and she's willing to meet a deductible before paying a copayment or coinsurance for care.

### Solutions:

- \$500 Deductible Plan
- \$1,000 Deductible Plan
- \$1,500 Deductible Plan

By choosing among our deductible plans, individuals can receive quality care when it's needed. Members can have peace of mind because they're prepared for health emergencies and have access to preventive care and preferred rates on select fitness club memberships as part of their premium. Once the deductibles are met, members pay copayments or coinsurance for services subject to the deductibles.

<sup>2</sup>These examples are for illustrative purposes only. Individual situations will vary depending on the specifics of the health care plan and individual contributions.



# UNDERSTANDING HSAs

## HEALTH SAVINGS ACCOUNTS (HSAs)

Kaiser Permanente Custom Care HealthInvestor (HSA) is a tax-exempt health savings account (HSA) built around Kaiser Permanente HSA-qualified high deductible health plans. It allows individuals and families to pay for current health care expenses and to save for future qualified medical expenses and retiree health expenses on a tax-free basis.<sup>3</sup> Plus, it's an excellent way to help clients who are struggling with the high cost of health care.

HealthInvestor (HSA) highlights:

- Combines a Kaiser Permanente HSA-qualified high deductible health plan (HDHP) with the CarePay<sup>®</sup> HSA, an employee financial account.<sup>4</sup>
- The CarePay HSA is owned by the employee.
- Contributions are made by the individual.
- Money invested in HealthInvestor (HSA) is tax deductible.
- CarePay is administered through Wells Fargo.

### Sample scenarios

#### Ben and Heather

Ben is 45 and his wife, Heather, is 39. They enroll in the \$0/\$1,500 Deductible Plan with HSA with family coverage for themselves and their two children, and Ben opens a health savings account. They decide to contribute \$3,000 to the health savings account.

Ben and Heather's health care plan coverage:

- Family deductible: \$3,000
- Annual family out-of-pocket maximum: \$3,000

During the year, Ben and Heather's family has eligible health care expenses of \$5,200, excluding preventive care, which is covered at 100 percent and is not subject to the deductible. They choose to pay \$3,000 of these expenses from the health savings account. The \$3,000 from the health savings account satisfies their health plan deductible and fulfills their plan's annual out-of-pocket maximum. After this, their plan covers 100 percent of the

remaining \$2,200 of health care expenses, as well as any other covered charges, through the end of the year.

#### Alicia

Alicia, 28, enrolls in the \$30/\$2,700 Deductible Plan with HSA with individual coverage for herself and opens a health savings account. She decides to contribute the maximum of \$2,900.

Alicia's health care plan coverage:

- Individual deductible: \$2,700
- Annual individual out-of-pocket maximum: \$5,250

During the year, Alicia has eligible health care expenses of \$1,000, plus preventive care charges of \$300 that are not subject to the deductible. Because her deductible is \$2,700, she's responsible for all of these expenses. She chooses to pay for only \$700 of these expenses from her health savings account because she wants to start saving for her future health care needs. She pays the remaining \$600 out-of-pocket. In total, the \$1,300 she has paid applies toward her \$5,250 annual out-of-pocket maximum, and the \$1,000 of expenses for nonpreventive care applies toward her plan's \$2,700 deductible.

<sup>3</sup>The tax references in this brochure relate to federal income tax only. Consult with your financial or tax advisor for more information about state income tax laws.

<sup>4</sup>CarePay<sup>®</sup> is a registered trademark of Kaiser Permanente identifying financial products our members can access through our arrangements with preferred financial providers. Your CarePay HSA is provided and administered by Wells Fargo Bank, N.A., which acts as trustee of the Wells Fargo Health Savings Accounts. Kaiser Permanente 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. Members can use their CarePay HSA Visa<sup>®</sup> debit card anywhere Visa is accepted, not limited to Kaiser Permanente facilities. For information about a Wells Fargo HSA, please contact Wells Fargo toll free at 1-866-890-8308.







# UNDERWRITING GUIDELINES

## GETTING DOWN TO BUSINESS

### Underwriting guidelines

Kaiser Permanente for Individuals and Families is a medically underwritten product, and acceptance is not guaranteed. Each individual applying must answer a series of questions on medical history. Completeness of the answers to the medical questionnaire is critical to the timeliness of the underwriting, approval, and enrollment processes. Incomplete applications not only require additional contacts with the prospect, but also frequently delay the potential date of coverage for approved individuals. Applications may be submitted either through a paper format with each applicant providing a signature, or through our Web site [kp.org/individuals](http://kp.org/individuals). Applicants are measured in four specific areas:

- Diagnosed medical history
- Height/weight
- Tobacco usage as a behavior
- Prescription medications currently used

### General principles

Applicants who are approved for membership in this product do not have pre-existing conditions that are (a) chronic, (b) life affecting, and (c) predictive of high utilization and costly treatment (including many but certainly not all prescription medications). Based on their prior experiences with various carriers, some individuals are concerned about sharing medical history. Kaiser Foundation Health Plan, Inc., does not share person-specific information with any outside organizations or agencies (for example, Medical Information Bureau), except as provided for by federal or state regulations. Therefore, we urge all interested persons to apply for Kaiser Permanente for Individuals and Families.

### Underwriting

- Underwriting decisions are based solely on the information provided in response to the medical questionnaire; application processors may also reference prior Kaiser Permanente medical records for current or previous members. All medical history is considered, but only within the five years preceding the date of application.

- Medical history older than five years is not taken into account.
- Persons with current or prior Kaiser Permanente membership (whether group or individual) are evaluated by our underwriting guidelines and are also evaluated against their past utilization of Kaiser Foundation Health Plan.
- In almost all cases, chronic conditions are reason for denial. Acute conditions will generally cause denial until they have been resolved.
- Persons with conditions covered by open workers' compensation claims will be denied until such times as they are discharged as permanent and stable.
- Height/weight standards are measured with reference to BMI (body mass index) and are denied if they fall outside normal to minimally overweight or minimally underweight ranges (referencing industry standards). See tables on pages 11–13.
- Tobacco history, because it is a behavior rather than a medical condition, is not subject to the five-year look-back restriction; we evaluate this behavior over the full span of time during which such products have been used. A person's risk as related to tobacco use is based on calculations that include the type of tobacco product used, the quantity consumed on a regular basis, the length of time an applicant has been using tobacco products, and the amount of time (if applicable) since tobacco use had been discontinued.
- Kaiser Permanente for Individuals and Families is a portfolio of products (for example, some HMO copayment plans, some HMO deductible plans, and some high deductible plans with Health Savings Account compatibility). It is, therefore, possible that applicants may be eligible for some plans but not others.
- Beginning in 2008, there will be continuation coverage on the family account available for students in good standing, from age 19 until the first of the month following their 23rd birthday.
- Persons eligible for Medicare are not eligible for Kaiser Permanente for Individuals and Families. Brokers may wish to remind their clients that even those whose work history leaves them unqualified for Medicare may buy



# ELIGIBILITY

into the program. This is our current practice. In the future, we may consider additional and/or alternative procedures for applicants who have been Kaiser Permanente members in the past.

- Dual coverage is not permitted. This has particular importance when an individual may be seeking coverage on multiple plans where deductibles are involved for one or both plans.
- Newborns and newly adopted children of existing Kaiser Permanente for Individuals and Families members are eligible for enrollment without medical underwriting, so long as the enrollment takes place within 31 days of the birth or designation of the right to control health care.
- All California applicants must provide either a Social Security number or Individual Taxpayer Identification Number in order to be enrolled. At present, the Social Security number requirement is strictly applied to all subscriber members but may be relaxed for infants.
- Child-only accounts must have an adult as the noncovered subscriber.
- The address provided on the application must be within the plan coverage area. If a student, for example, is a resident in a covered ZIP code but the financially responsible party resides outside of the plan coverage

area, it must be the student's residential address that is provided. The membership address (a physical address; P.O. boxes are not allowed) is used to determine facility designation as well as plan eligibility.

- An application that is submitted to add a new member to an existing account must clearly reference the current subscriber's name and medical record number.<sup>5</sup>
- New members to Kaiser Permanente for Individuals and Families are followed to monitor that their utilization matches the healthy profile for this product. If it is determined that early utilization indicates a probable discrepancy between the information provided on the Kaiser Permanente for Individuals and Families medical questionnaire and actual utilization (pharmacy, diagnostics, and encounter data), an individual's membership may be rescinded.
- Enrolled members should not obtain services prior to the effective date (shown on both the approval letter and the carrier cardholder for the Kaiser Permanente ID cards). If they do obtain services prior to that date, they may be billed at nonmember rates.

<sup>5</sup> The Colorado, Mid-Atlantic States, and Ohio regions do not have this requirement.



# ELIGIBILITY



## Prescription medications

During the underwriting process for Kaiser Permanente for Individuals and Families, application processors evaluate all prescription medications based not only on what conditions are treated but also their cost. In some instances, the condition may be eligible for underwriting but the medication may be too costly to cover. In such cases, we will offer coverage under a plan that does not provide prescription coverage. We also evaluate carefully those prescriptions that are being taken without a condition listed and those being taken for an off-label usage.

## Commonly denied prescription medications

The following list is not intended to be all-inclusive. Rather, it is what our experience indicates are the most commonly denied prescription medications:

Aciphex	Interferon
Actos	Isoniazid (INH)
Adderall	Klonopin
Asacol	Lexapro
Avandia	Lipitor
Bupropion	Metformin
Buspar	Methotrexate
Coumadin	Morphine
Crestor	Nexium
Digoxin	Oxazepam
Effexor	Plavix
Flomax	Prednisone
Glucophage	Risperdal
Glucotrol	Serzone
Glucovance	Sulfasalazine
Glypizide	Tamoxifen
Gold	Tylenol with codeine
Hydrocodone	Vicodin
Imipramine	Warfarin
Imitrex	Wellbutrin
Insulin	

Two medications for anxiety (e.g., Alprazolam and Xanax)

Two medications for depression (e.g., Amitriptyline and Prozac)



## Reasons for possible denial

Medical history (within five years) that may result in denial include:

- AIDS
- Alcoholic beverages, significant daily or weekly consumption
- Aneurysm
- Angina
- Angioplasty
- Asthma treated with prednisone
- Asthma with three or more Emergency Department visits or hospitalizations within the last year
- Atrial fibrillation
- Back/neck injury, current, requiring treatment or surgery
- Bladder stones, current
- Breast implants (silicone) still in place
- Cancer with the exception of a skin cancer that has been removed
- Cirrhosis
- Coronary artery bypass
- Crohn's disease
- Cystic fibrosis
- Diabetes (type 1, type 2, and gestational)
- Eating disorders
- Emphysema
- Endometriosis
- Fibromyalgia
- Gallstones present, or recent history with gallbladder still present
- Heart attack
- Heart failure, congestive (CHF)
- Heart or valvular disease
- Hemophilia
- Hepatitis (active, chronic, or carrier status)
- High blood pressure, uncontrolled
- High cholesterol, uncontrolled
- Illegal drugs used, prescription drugs not specifically prescribed for the applicant, or abused prescription drugs
- Inpatient episodes, more than two within the last year (nonpregnancy)
- Joint replacement
- Kidney failure, chronic
- Kidney stones, current
- Lupus
- Mental health inpatient episode within last two years
- Muscular dystrophy
- Nephritis
- Nephrotic syndrome
- Organ transplant
- Orthopedic/arthritis conditions interfering with daily living
- Osteomyelitis
- Outpatient visits, more than eight within the last year (nonpregnancy)
- Pacemaker or fibrillator implant
- Pain syndromes, chronic
- Polycystic kidneys
- Polycystic ovary disease
- Pregnancy, current (applies both to female and male applicants where intended insured will be responsible for a newborn within the next nine months)
- Prostate condition requiring treatment or surgery
- Psychosis
- Pulmonary disease, chronic obstructive (COPD)
- Rectocele or cystocele, unrepaired
- Rheumatoid arthritis
- Seizure disorder
- Sexually transmitted disease (STD) within the last year
- Stroke or transient ischemic attack
- Substance abuse, participation in a substance abuse program for the applicant
- Suicide attempt, single or multiple

*(continued on next page)*

# ELIGIBILITY

- Tachycardia, ventricular or supraventricular
- Treatment, surgery, procedure, or examination recommended or scheduled within the last year that has not yet taken place
- Tuberculosis (pulmonary) within the last two years
- Ulcer currently under treatment
- Ulcerative colitis
- Umbilical hernia, unrepaired
- Valve regurgitation

## **Unexplained symptoms/conditions**

Individuals who indicate that they have unexplained symptoms or conditions will generally be denied. Failure to seek professional health care evaluation, diagnosis, and treatment when it is appropriate is an indicator of predictably high and/or costly utilization.

## **Body mass index charts**

The following worksheets show body mass index (BMI) converted to weight ranges for height. The recommended scoring ranges are based on Centers for Disease Control and Prevention (CDC) tables. Weights indicated in pounds.





# BMI TABLES

## ADULT HEIGHT AND WEIGHT GUIDELINES, AGES 19+

DEBIT POINTS			15		0		15		35		60		100
HEIGHT IN FEET/INCHES	HEIGHT IN INCHES	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT
4	0	48	60	61	82	83	98	99	115	116	131	132	
4	1	49	63	64	85	86	102	103	120	121	137	138	
4	2	50	65	66	89	90	106	107	124	125	142	143	
4	3	51	68	69	92	93	111	112	129	130	148	149	
4	4	52	71	72	96	97	115	116	135	136	154	155	
4	5	53	74	75	99	100	119	120	140	141	160	161	
4	6	54	76	77	103	104	124	125	145	146	166	167	
4	7	55	79	80	107	108	129	130	151	152	172	173	
4	8	56	82	83	111	112	133	134	156	157	178	179	
4	9	57	85	86	115	116	138	139	162	163	185	186	
4	10	58	88	89	119	120	143	144	167	168	191	192	
4	11	59	91	92	123	124	148	149	173	174	198	199	
5	0	60	94	95	128	129	153	154	179	180	205	206	
5	1	61	97	98	132	133	158	159	185	186	212	213	
5	2	62	101	102	136	137	163	164	191	192	219	220	
5	3	63	104	105	141	142	169	170	198	199	226	227	
5	4	64	107	108	145	146	174	175	204	205	233	234	
5	5	65	111	112	150	151	180	181	210	211	240	241	
5	6	66	114	115	154	155	185	186	217	218	248	249	
5	7	67	117	118	159	160	191	192	223	224	255	256	
5	8	68	121	122	164	165	197	198	230	231	263	264	
5	9	69	125	126	169	170	202	203	237	238	271	272	
5	10	70	128	129	174	175	208	209	244	245	279	280	
5	11	71	132	133	179	180	214	215	251	252	287	288	
6	0	72	136	137	184	185	220	221	258	259	295	296	
6	1	73	139	140	189	190	227	228	265	266	303	304	
6	2	74	143	144	194	195	233	234	273	274	312	313	
6	3	75	147	148	199	200	239	240	280	281	320	321	
6	4	76	151	152	205	206	246	247	288	289	329	330	
6	5	77	155	156	210	211	252	253	295	296	337	338	
6	6	78	159	160	215	216	259	260	303	304	346	347	
6	7	79	163	164	221	222	265	266	311	312	355	356	
6	8	80	168	169	227	228	272	273	319	320	364	365	
6	9	81	172	173	232	233	279	280	327	328	373	374	
6	10	82	176	177	238	239	286	287	335	336	383	384	
6	11	83	180	181	244	245	293	294	343	344	392	393	
7	0	84	185	186	250	251	300	301	351	352	401	402	

# BMI TABLES

## CHILD HEIGHT AND WEIGHT GUIDELINES, AGES 3–18

DEBIT POINTS			25	0	20			55	100	
HEIGHT IN FEET/INCHES	HEIGHT IN INCHES	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	
3	0	36	24	25	51	52	61	62	65	66
3	1	37	25	26	54	55	64	65	68	69
3	2	38	27	28	57	58	68	69	72	73
3	3	39	28	29	60	61	71	72	76	77
3	4	40	30	31	63	64	75	76	80	81
3	5	41	31	32	66	67	79	80	84	85
3	6	42	33	34	69	70	83	84	88	89
3	7	43	34	35	73	74	87	88	92	93
3	8	44	36	37	76	77	91	92	96	97
3	9	45	37	38	80	81	95	96	101	102
3	10	46	39	40	83	84	99	100	105	106
3	11	47	41	42	87	88	104	105	110	111
4	0	48	43	44	91	92	108	109	115	116
4	1	49	44	45	95	96	113	114	120	121
4	2	50	46	47	99	100	117	118	124	125
4	3	51	49	50	103	104	122	123	129	130
4	4	52	50	51	107	108	127	128	135	136
4	5	53	52	53	111	112	132	133	140	141
4	6	54	54	55	115	116	137	138	145	146
4	7	55	56	57	119	120	142	143	151	152
4	8	56	58	59	124	125	147	148	156	157
4	9	57	60	61	128	129	153	154	162	163
4	10	58	62	63	133	134	158	159	167	168
4	11	59	64	65	138	139	163	164	173	174
5	0	60	67	68	142	143	169	170	179	180
5	1	61	69	70	147	148	175	176	185	186
5	2	62	71	72	152	153	180	181	191	192
5	3	63	73	74	157	158	186	187	198	199
5	4	64	76	77	162	163	192	193	204	205
5	5	65	78	79	167	168	198	199	210	211
5	6	66	81	82	172	173	204	205	217	218
5	7	67	83	84	178	179	211	212	223	224
5	8	68	86	87	183	184	217	218	230	231
5	9	69	88	89	189	190	223	224	237	238
5	10	70	91	92	194	195	230	231	244	245
5	11	71	93	94	200	201	237	238	251	252
6	0	72	96	97	205	206	243	244	258	259
6	1	73	99	100	211	212	250	251	265	266
6	2	74	101	102	217	218	257	258	273	274
6	3	75	104	105	223	224	264	265	280	281
6	4	76	107	108	229	230	271	272	288	289
6	5	77	110	111	235	236	278	279	295	296
6	6	78	113	114	241	242	286	287	303	304



**INFANT HEIGHT AND WEIGHT GUIDELINES, AGES 0–24 MONTHS**

DEBIT POINTS			100	0		45		100
HEIGHT IN FEET/INCHES	HEIGHT IN INCHES	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT	MINIMUM WEIGHT	MAXIMUM WEIGHT
1	6	18	6	7	12	13	15	16
1	7	19	7	8	14	15	17	18
1	8	20	7	8	15	16	19	20
1	9	21	8	9	17	18	21	22
1	10	22	9	10	19	20	23	24
1	11	23	10	11	20	21	25	26
2	0	24	11	12	22	23	27	28
2	1	25	12	13	24	25	29	30
2	2	26	13	14	26	27	32	33
2	3	27	13	14	28	29	34	35
2	4	28	14	15	30	31	37	38
2	5	29	16	17	32	33	39	40
2	6	30	17	18	35	36	42	43
2	7	31	18	19	37	38	45	46
2	8	32	19	20	39	40	48	49
2	9	33	20	21	42	43	51	52
2	10	34	21	22	44	45	54	55
2	11	35	23	24	47	48	58	59
3	0	36	24	25	51	52	61	62



# COPAYMENT PLANS

EFFECTIVE 1/1/08–6/1/08

FEATURES	\$50 COPAYMENT PLAN	\$25 COPAYMENT PLAN
Medical calendar-year deductible		
Individual	None	None
Family	None	None
Annual out-of-pocket maximum		
Individual	\$3,500	\$2,500
Family	\$7,000	\$5,000
Lifetime benefit maximum	None	None
<b>PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)</b>		
Primary and specialty care visits (includes routine and urgent care appointments)	\$50 per visit	\$25 per visit
Well-child visits from 0 to 23 months	\$15 per visit	No charge
Family planning visits	\$50 per visit	\$25 per visit
Scheduled prenatal care and first postpartum visit	\$15 per visit	No charge
Eye exams	\$50 per visit	\$25 per visit
Hearing tests	\$50 per visit	\$25 per visit
Physical, occupational, and speech therapy visits	\$50 per visit	\$25 per visit
<b>OUTPATIENT SERVICES</b>		
Outpatient surgery	\$250 per procedure	\$100 per procedure
Allergy injection visits	\$5 per visit	\$5 per visit
Vaccines (immunizations)	No charge	No charge
Most X-rays and lab tests	\$10 per encounter	\$10 per encounter
Health education		
Individual visits	\$50 per visit	\$25 per visit
Group visits	No charge	No charge
<b>HOSPITALIZATION SERVICES</b>		
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	\$500 per day	\$200 per day
<b>EMERGENCY HEALTH COVERAGE</b>		
Emergency Department visits	\$150 per visit (waived if admitted directly to the hospital)	\$100 per visit (waived if admitted directly to the hospital)
<b>AMBULANCE SERVICES</b>		
Emergency ambulance services	\$300 per trip	\$100 per trip
<b>PRESCRIPTION DRUG COVERAGE</b>		
Covered items in accord with our drug formulary when obtained at Plan pharmacies	Most prescription drugs are not covered	
Generic drugs		\$10 up to a 30-day supply
Brand-name drugs		\$35 up to a 30-day supply
Mail-order program		\$20 generic/\$70 brand for 100-day supply of most maintenance drugs

FEATURES	\$50 COPAYMENT PLAN	\$25 COPAYMENT PLAN
<b>DURABLE MEDICAL EQUIPMENT (DME)</b> DME used in the home in accord with our DME formulary Prosthetic and orthotic devices	Not covered No charge	Not covered No charge
<b>MENTAL HEALTH SERVICES</b> Inpatient psychiatric care  Outpatient visits Individual visits  Group therapy visits  Note: Visit and day limits do not apply to severe mental illness and serious emotional disturbances of children as described in the "Benefits and Cost Sharing" section of the <i>Membership Agreement</i> .	\$500 per day (up to 30 days per calendar year)  \$50 per visit (up to 20 individual/group visits per calendar year) \$25 per visit (up to 20 individual/group visits per calendar year) Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year	\$200 per day (up to 30 days per calendar year)  25 per visit (up to 20 individual/group visits per calendar year) \$12 per visit (up to 20 individual/group visits per calendar year) Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year
<b>CHEMICAL DEPENDENCY SERVICES</b> Inpatient detoxification Outpatient individual therapy visits Outpatient group therapy visits Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$500 per day \$50 per visit \$5 per visit \$100 per admission	\$200 per day \$25 per visit \$5 per visit \$100 per admission
<b>HOME HEALTH SERVICES</b> Home health care (up to 100 two-hour visits per calendar year)	No charge	No charge
<b>OTHER</b> Skilled nursing facility care  Hospice care	No charge (up to 100 days per benefit period) No charge	No charge (up to 100 days per benefit period) No charge

**Note:** Kaiser Permanente plans do not include a pre-existing condition clause.

<sup>1</sup>The annual out-of-pocket maximum is the limit to the total amount that an individual or family must pay for certain services in a calendar year (as discussed in the *Evidence of Coverage*).

<sup>2</sup>Scheduled prenatal visits and the first postpartum visit.

<sup>3</sup>23 months or younger.

<sup>4</sup>Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

<sup>5</sup>This service is not subject to a deductible.

<sup>6</sup>Visit or day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

<sup>7</sup>Most DME for home use is not covered. Please refer to your *Evidence of Coverage* for a description of limited covered items.

<sup>8</sup>Kaiser Permanente members are entitled to a 20 percent discount on eyeglasses and contact lenses purchased at Kaiser Permanente optical centers. These discounts may not be coordinated with any other Health Plan vision benefit. The discounts do not apply to any sale, promotional, or packaged eyewear program, for any contact lenses extended purchase agreement, or to low-vision aids or devices. Visit [kp.org/2020](http://kp.org/2020) for Kaiser Permanente optical locations.

<sup>9</sup>Allowance toward the cost of eyeglass lenses, frames, and contact lenses fitting and dispensing every 24 months.



# DEDUCTIBLE PLANS

EFFECTIVE 1/1/08–6/1/08

FEATURES	\$1,500 DEDUCTIBLE PLAN	\$1,000 DEDUCTIBLE PLAN	\$500 DEDUCTIBLE PLAN
Medical calendar-year deductible			
Individual	\$1,500	\$1,000	\$500
Family	\$3,000	\$2,000	\$1,000
Annual out-of-pocket maximum			
Individual	\$3,500	\$1,500	\$2,500
Family	\$7,000	\$3,000	\$5,000
Lifetime benefit maximum	None	None	None
<b>PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)</b>			
Primary and specialty care visits (includes routine and urgent care appointments)	\$30 per visit <sup>1</sup>	\$25 per visit <sup>1</sup>	\$20 per visit <sup>1</sup>
Well-child visits from 0 to 23 months	\$30 per visit <sup>1</sup>	\$10 per visit <sup>1</sup>	No charge <sup>1</sup>
Family planning visits	\$30 per visit <sup>1</sup>	\$25 per visit <sup>1</sup>	\$20 per visit <sup>1</sup>
Eye exams	\$30 per visit <sup>1</sup>	\$25 per visit <sup>1</sup>	\$20 per visit <sup>1</sup>
Hearing tests	\$30 per visit <sup>1</sup>	\$25 per visit <sup>1</sup>	\$20 per visit <sup>1</sup>
Physical, occupational, and speech therapy visits	\$30 per visit after deductible	\$25 per visit after deductible	\$20 per visit after deductible
<b>OUTPATIENT SERVICES</b>			
Outpatient surgery	\$250 per procedure after deductible	\$150 per procedure after deductible	\$50 per procedure after deductible
Allergy injection visits	\$5 per visit after deductible	\$5 per visit after deductible	\$5 per visit after deductible
Vaccines (immunizations)	No charge <sup>1</sup>	No charge <sup>1</sup>	No charge <sup>1</sup>
Most X-rays and lab tests	\$10 per encounter after deductible	\$10 per encounter after deductible	\$10 per encounter after deductible
Health education			
Individual visits	\$30 per visit <sup>1</sup>	\$25 per visit <sup>1</sup>	\$20 per visit <sup>1</sup>
Group visits	No charge <sup>1</sup>	No charge <sup>1</sup>	No charge <sup>1</sup>
<b>HOSPITALIZATION SERVICES</b>			
Room and board, surgery, anesthesia X-rays, lab tests, and medications	\$500 per day after deductible	\$250 per day after deductible	\$100 per day after deductible
<b>EMERGENCY HEALTH COVERAGE</b>			
Emergency Department visits	\$150 per visit after deductible (waived if admitted directly to the hospital)	\$100 per visit after deductible (waived if admitted directly to the hospital)	\$100 per visit after deductible (waived if admitted directly to the hospital)
<b>AMBULANCE SERVICES</b>			
Emergency ambulance services	\$150 per trip after deductible	\$150 per trip after deductible	\$150 per trip after deductible
<b>PRESCRIPTION DRUG COVERAGE</b>			
Covered items in accord with our drug formulary when obtained at Plan pharmacies			
Generic drugs	\$10 up to a 30-day supply	\$10 up to a 30-day supply	\$10 up to a 30-day supply
Brand-name drugs	\$35 up to a 30-day supply	\$35 up to a 30-day supply	\$35 up to a 30-day supply
Mail-order program	\$20 generic/\$70 brand for 100-day supply for most maintenance drugs	\$20 generic/\$70 brand for 100-day supply for most maintenance drugs	\$20 generic/\$70 brand for 100-day supply for most maintenance drugs

<sup>1</sup>These services are not subject to the deductible.

FEATURES	\$1,500 DEDUCTIBLE PLAN	\$1,000 DEDUCTIBLE PLAN	\$500 DEDUCTIBLE PLAN
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>			
DME used in the home in accord with our DME formulary	30% coinsurance	20% coinsurance up to a \$1,000 calendar-year benefit limit <sup>1</sup>	20% coinsurance up to a \$2,000 calendar-year benefit limit <sup>1</sup>
Prosthetic and orthotic devices	No charge	No charge	No charge
<b>MENTAL HEALTH SERVICES</b>			
Inpatient psychiatric care	\$500 per day after deductible (up to 10 days per calendar year)	\$250 per day after deductible (up to 10 days per calendar year)	\$100 per day after deductible (up to 30 days per calendar year)
Outpatient visits			
Individual visits	\$30 per visit after deductible (up to a total of 10 individual/group visits per calendar year)	\$25 per visit after deductible (up to a total of 10 individual/group visits per calendar year)	\$20 per visit after deductible (up to a total of 20 individual/group visits per calendar year)
Group visits	\$15 per visit after deductible (up to a total of 10 individual/group visits per calendar year)	\$12 per visit after deductible (up to a total of 10 individual/group visits per calendar year)	\$10 per visit after deductible (up to a total of 20 individual/group visits per calendar year)
	Up to 30 additional group therapy visits that meet Medical Group criteria in the same calendar year	Up to 30 additional group therapy visits that meet Medical Group criteria in the same calendar year	Up to 30 additional group therapy visits that meet Medical Group criteria in the same calendar year
Note: Visit and day limits do not apply to severe mental illness and serious emotional disturbances of children as described in the "Benefits and Cost Sharing" section of the <i>Membership Agreement</i> .			
<b>CHEMICAL DEPENDENCY SERVICES</b>			
Inpatient detoxification	\$500 per day after deductible	\$250 per day after deductible	\$100 per day after deductible
Outpatient individual therapy visits	\$30 per visit after deductible	\$25 per visit after deductible	\$20 per visit after deductible
Outpatient group therapy visits	\$5 per visit after deductible	\$5 per visit after deductible	\$5 per visit after deductible
Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission after deductible	\$250 per admission after deductible	\$100 per admission after deductible
<b>HOME HEALTH SERVICES</b>			
Home health care (up to 100 two-hour visits per calendar year)	No charge <sup>1</sup>	No charge <sup>1</sup>	No charge <sup>1</sup>
<b>OTHER</b>			
Skilled nursing facility care	\$50 per day after deductible (up to 60 days per benefit period)	No charge after deductible (up to 100 days per benefit period)	No charge after deductible (up to 100 days per benefit period)
Hospice care	No charge <sup>1</sup>	No charge <sup>1</sup>	No charge <sup>1</sup>

<sup>1</sup>These services are not subject to the deductible.

# HSA-QUALIFIED PLANS

EFFECTIVE 1/1/08–6/1/08

FEATURES	\$30/\$2,700 PLAN WITH HSA MEMBER PAYS	\$0/\$2,700 PLAN WITH HSA MEMBER PAYS	\$0/\$1,500 PLAN WITH HSA MEMBER PAYS
Medical calendar-year deductible			
Individual	\$2,700	\$2,700	\$1,500
Family	\$5,450	\$5,450	\$3,000
Annual out-of-pocket maximum			
Individual	\$5,250	\$2,700	\$1,500
Family	\$10,500	\$5,450	\$3,000
Lifetime benefit maximum	None	None	None
<b>PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)</b>			
Primary and specialty care visits (includes routine and urgent care appointments)	\$30 per visit after deductible	No charge after deductible	No charge after deductible
Well-child visits from 0 to 23 months	\$10 per visit <sup>1</sup>	No charge <sup>1</sup>	No charge <sup>1</sup>
Family planning visits	\$30 per visit after deductible	No charge after deductible	No charge after deductible
Scheduled prenatal care	\$10 per visit <sup>1</sup>	No charge <sup>1</sup>	No charge <sup>1</sup>
First postpartum visit	\$10 after deductible	No charge after deductible	No charge after deductible
Eye exams	\$30 per visit after deductible	No charge after deductible	No charge after deductible
Hearing tests	\$30 per visit after deductible	No charge after deductible	No charge after deductible
Chiropractic office visits	Not covered	Not covered	Not covered
Physical, occupational, and speech therapy visits	\$30 per visit after deductible	No charge after deductible	No charge after deductible
<b>OUTPATIENT SERVICES</b>			
Outpatient surgery	30% coinsurance per procedure after deductible	No charge after deductible	No charge after deductible
Allergy injection visits	\$5 per visit after deductible	No charge after deductible	No charge after deductible
Vaccines (immunizations)	No charge <sup>1</sup>	No charge <sup>1</sup>	No charge <sup>1</sup>
Most X-rays and lab tests	\$10 per encounter after deductible	No charge after deductible	No charge after deductible
Health education			
Individual visits	\$30 per visit after deductible	No charge after deductible	No charge after deductible
Group visits	No charge after deductible	No charge after deductible	No charge after deductible
<b>HOSPITALIZATION SERVICES</b>			
Room and board, surgery, anesthesia X-rays, lab tests, and medications	30% coinsurance per admission after deductible	No charge after deductible	No charge after deductible
<b>EMERGENCY HEALTH COVERAGE</b>			
Emergency Department visits	30% coinsurance per admission after deductible (waived if admitted directly to hospital)	No charge after deductible	No charge after deductible
<b>AMBULANCE SERVICES</b>			
Emergency ambulance services	\$100 per trip after deductible	No charge after deductible	No charge after deductible
<b>PRESCRIPTION DRUG COVERAGE</b>			
Covered items in accord with our drug formulary when obtained at Plan pharmacies			
Generic drugs	\$10 up to a 30-day supply after deductible	No charge up to a 100-day supply after deductible	No charge up to a 100-day supply after deductible
Brand-name drugs	\$30 up to a 30-day supply after deductible	No charge up to a 100-day supply after deductible	No charge up to a 100-day supply after deductible

<sup>1</sup>These services are not subject to the deductible.



FEATURES	\$30/\$2,700 PLAN WITH HSA MEMBER PAYS	\$0/\$2,700 PLAN WITH HSA MEMBER PAYS	\$0/\$1,500 PLAN WITH HSA MEMBER PAYS
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>			
DME used in the home in accord with our DME formulary	Not covered	Not covered	Not covered
Prosthetic and orthotic devices	No charge	No charge	No charge
<b>MENTAL HEALTH SERVICES</b>			
Inpatient psychiatric care	30% coinsurance per admission after deductible (up to 30 days per calendar year)	No charge after deductible (up to 30 days per calendar year)	No charge after deductible (up to 30 days per calendar year)
Outpatient visits			
Individual visits	\$30 per visit (up to 20 visits per calendar year)	No charge after deductible (up to 20 visits per calendar year)	No charge after deductible (up to 20 visits per calendar year)
Group visits	\$15 per visit (up to 20 visits per calendar year)	No charge after deductible (up to 20 visits per calendar year)	No charge after deductible (up to 20 visits per calendar year)
Note: Visit and day limits do not apply to severe mental illness and serious emotional disturbances of children as described in the "Benefits and Cost Sharing" section of the <i>Membership Agreement</i> .			
<b>CHEMICAL DEPENDENCY SERVICES</b>			
Inpatient detoxification	30% coinsurance per admission after deductible	No charge after deductible	No charge after deductible
Outpatient individual therapy visits	\$30 per visit after deductible	No charge after deductible	No charge after deductible
Outpatient group therapy visits	\$5 per visit after deductible	No charge after deductible	No charge after deductible
Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission after deductible	No charge after deductible	No charge after deductible
<b>HOME HEALTH SERVICES</b>			
Home health care (up to 100 two-hour visits per calendar year)	No charge after deductible	No charge after deductible	No charge after deductible
<b>OTHER</b>			
Skilled nursing facility care (100 days per benefit period)	30% coinsurance per admission after deductible	No charge after deductible	No charge after deductible
Hospice care	No charge after deductible	No charge after deductible	No charge after deductible

Or visit us online: [kp.org/applyonline/scal](http://kp.org/applyonline/scal)



## DETAILS

### FORMS

If you need forms, call the Broker Connection Team at **1-800-789-4661, option 6**. Or visit **brokers.kp.org/redirects/kpif\_stepstoapply** to download, print, or complete applications online. Follow the instructions below, or call **1-800-207-5084** if you have questions.

- 1) Visit **kp.org/individuals** and register if you haven't already done so. If you're already registered, click on "Sign in" to proceed.
- 2) Complete the onscreen application form for Kaiser Permanente for Individual and Family enrollees, or print the form and complete it by hand.
- 3) Fill out a medical questionnaire for each enrollee.
- 4) Click "Submit" to send the application through our secure Web site. You can also fax the printed form to 1-866-816-5139 or mail it to:

Individuals and Families  
Kaiser Permanente  
P.O. Box 7104  
Pasadena, CA 91109-9835

### CHANGES FOR INDIVIDUALS AND FAMILIES

Stay current on changes that affect your clients by visiting **kp.org/individuals**. To give you more time, we've moved the deadline to the 23rd of each month.

If an enrollee's application is received **on or before** the 23rd of a given month (e.g., December 23), coverage should begin on the first of the following month (e.g., January 1).

If an enrollee's application is received **after** the 23rd of a given month (e.g., December 27), coverage is delayed a month, and should begin on the first of the subsequent month (e.g., February 1).

## CONTACTS

If you have questions, you can contact your Kaiser Permanente sales representative, visit **kp.org/individuals**, or call **1-800-789-4661, option 6**.

For help with online applications, call **1-800-207-5084**.

### Member Service Call Center

- **1-800-464-4000** English
- **1-800-788-0616** Spanish
- **1-800-757-7585** Chinese dialects
- **1-800-777-1370** TTY for the deaf, hard of hearing, or speech impaired



**kp.org**

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