



Important notice

Health plans are undergoing many changes due to the passage of the Patient Protection and Affordable Care Act (PPACA). At Kaiser Permanente, we want to help you keep informed about how the federal health reform law affects your individual and family health coverage.

Grandfathered coverage

Under PPACA, your coverage will be considered non-grandfathered coverage because you purchased a Kaiser Permanente for Individuals and Families plan after March 23, 2010.

Change in Kaiser Permanente for Individuals and Families plan offerings

The four copayment plans shown in this packet (\$10/\$20 Copay Option, \$20/\$30 Copay Option, \$30/\$40 Copay Option, and \$40/\$50 Copay Option) are no longer available for new sales.

- Members who enrolled in these discontinued plans prior to March 23, 2010, have grandfathered coverage and may maintain their plan coverage as shown.
- Members who enrolled in one of these four copayment plans after March 23, 2010, do not have grandfathered coverage. They will be notified of any plan changes as well as other plan options prior to their annual renewal.

Changes in coverage

Please note the following changes to all Kaiser Permanente for Individuals and Families plans (grandfathered and non-grandfathered):

The following changes are effective October 1, 2010, for all plans:

- Dependents can now be covered on your policy until they turn age 26.
- The preventive care package for all plans has been expanded to include a total of eighty (80) preventive services specified by PPACA. These preventive care services are available for no charge and are not subject to the medical deductible.

The following change is effective January 1, 2011, for all plans:

- Non-prescribed over-the-counter (OTC) medicine/drugs will no longer be qualified as eligible medical services under any health account (such as health savings accounts). Insulin is the only non-prescribed drug exception.

The information in this notice changes some of the information in the enclosed enrollment kit, which explains our Kaiser Permanente for Individuals and Families coverage effective

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February 1, 2010, through January 31, 2011. There may be additional benefit and eligibility revisions based on further clarification from our federal regulators. If so, we will notify you of these changes.

For more information about current plan coverage, please contact Customer Relations at **1-800-777-7902** (TTY 1-301-879-6380), 7:30 a.m. to 5:30 p.m., Monday through Friday.

For information about enrolling in a new plan, please call **1-800-494-5314**, 8 a.m. to 8 p.m., Monday through Friday, and 9 a.m. to 5 p.m., Saturday.

Thank you for choosing Kaiser Permanente as your health care provider.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
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CHOOSE A PLAN

HSA-QUALIFIED DEDUCTIBLE PLANS

What a deductible plan with an HSA option is and how it works



IN THIS BROCHURE

- Understanding HSAs (health savings accounts)
- Benefit highlights
- Meet the Howards

Good health is an investment in life.

Save for future expenses with an HSA-qualified deductible plan

You may be looking for a plan that not only saves you money, but also allows you to save for health expenses today and in the future. Our HSA-qualified deductible plans, designed for people who want to take charge of their health care costs, may be right for you. When you enroll in one of these plans and choose to open a health savings account (HSA), you can use tax-free savings to pay for qualified medical expenses, such as deductibles, copays, and coinsurance.¹

How an HSA-qualified plan works

An HSA-qualified plan works much like a traditional deductible plan. You pay full charges for certain services out of pocket until you reach your deductible, and then you're eligible to pay a copay or coinsurance 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:

- Enroll in an HSA-qualified health care plan.
- If you qualify, open a health savings account.
- Contribute tax-deductible dollars to this account.
- 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.²

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

Other advantages of opening an HSA

- **Portability.** The money belongs to you, so if you change plans, you can take your HSA with you.
- **Unused funds roll over.** 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.
- **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.

¹Tax 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.

²Earnings 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.

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:

- Certain over-the-counter medications
- Eyeglasses and LASIK surgery
- Dental and orthodonture care
- Acupuncture
- Chiropractic services
- Hearing aids

For a complete list, see *Publication 502, Medical and Dental Expenses* at 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.



How to set up an HSA

You may set up your HSA through any financial institution that offers these accounts.¹ Kaiser Permanente has selected Wells Fargo Bank as our preferred health savings account trustee and administrator. For more information, visit the Wells Fargo Web site, wellsfargo.com/hsa.

¹Kaiser 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. 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 10 percent tax penalty. Please note that when Wells Fargo Health Benefit Services pays disbursements, it does not monitor whether they are for qualified medical expenses. It is the member's responsibility to determine whether expenses qualify for tax-free reimbursement from his or her HSA. For information about a Wells Fargo HSA, please contact Wells Fargo at 1-866-890-8308.

Benefit highlights

	\$1,250 Deductible/20% Plan with HSA Option	\$1,750 Deductible/20% Plan with HSA Option
Features		
Annual deductible (individual/family)	\$1,250/\$2,500	\$1,750/\$3,500
Annual out-of-pocket maximum (individual/family)	\$3,000/\$6,000	\$4,000/\$8,000
Lifetime maximum	None	
Benefits Services not subject to deductible unless otherwise indicated		
Preventive care		
Immunizations	No charge	
Routine physical exam	No charge	
Well-child exam	No charge	
Well-woman exam, mammogram, Pap smear	No charge	
Adult preventive care screening	No charge	
Outpatient services (per visit or procedure)		
Primary care office visit	\$20 copay (after deductible)	
Specialty care office visit	\$30 copay (after deductible)	
Outpatient surgery	20% of allowable charges (after deductible)	
Diagnostic labs and X-rays	No charge (after deductible)	
MRI, CT, and PET	\$100 copay (after deductible)	
Inpatient hospital care		
Hospital care and professional visits	\$500 copay per day, up to \$1,500 per admission (after deductible)	
Maternity coverage		
Prenatal care/One postpartum visit	No charge (after deductible)	
Delivery and inpatient well-baby care	\$500 copay per day, up to \$1,500 per admission (after deductible)	
Emergency and urgent care		
Emergency Department visit (waived if admitted)	\$100 copay (after deductible)	
Urgent care visit	\$30 copay (after deductible)	
Ambulance service	20% of allowable charges (after deductible)	
Prescription drugs (30-day supply filled at Kaiser Permanente pharmacy)		
Pharmacy deductible	Subject to medical deductible	
Annual prescription drug maximum	None	
Generic drug	\$10 copay (after deductible)	
Preferred brand/Nonpreferred brand drug	\$35 copay/\$50 copay (after deductible)	
Other		
Dental services	\$30 preventive visits and certain other services at discounted rates. See the <i>Preventive Dental Plan</i> flyer for details.	

\$2,500 Deductible/20% Plan with HSA Option	
Features	
\$2,500/\$5,000	Annual deductible (individual/family)
\$5,000/\$10,000	Annual out-of-pocket maximum (individual/family)
None	Lifetime maximum
Services not subject to deductible unless otherwise indicated	Benefits
Preventive care	
No charge	Immunizations
No charge	Routine physical exam
No charge	Well-child exam
No charge	Well-woman exam, mammogram, Pap smear
No charge	Adult preventive care screening
Outpatient services (per visit or procedure)	
\$20 copay (after deductible)	Primary care office visit
\$30 copay (after deductible)	Specialty care office visit
20% of allowable charges (after deductible)	Outpatient surgery
No charge (after deductible)	Diagnostic labs and X-rays
\$100 copay (after deductible)	MRI, CT, and PET
Inpatient hospital care	
\$500 copay per day, up to \$1,500 per admission (after deductible)	Hospital care and professional visits
Maternity coverage	
No charge (after deductible)	Prenatal care/One postpartum visit
\$500 copay per day, up to \$1,500 per admission (after deductible)	Delivery and inpatient well-baby care
Emergency and urgent care	
\$100 copay (after deductible)	Emergency Department visit (waived if admitted)
\$30 copay (after deductible)	Urgent care visit
20% of allowable charges (after deductible)	Ambulance service
(30-day supply filled at Kaiser Permanente pharmacy)	Prescription drugs
Subject to medical deductible	Pharmacy deductible
None	Annual prescription drug maximum
\$10 copay (after deductible)	Generic drug
\$35 copay/\$50 copay (after deductible)	Preferred brand/Nonpreferred brand drug
Other	
\$30 preventive visits and certain other services at discounted rates. See the <i>Preventive Dental Plan</i> flyer for details.	Dental services

These are only highlights of plan coverage and are not inclusive. For specific benefit information, reference the *Guide to Your 2010 Benefits and Services* (KFHP-NG-KPIF-DC for District of Columbia residents, KFHP-NG-KPIF-VA for Virginia residents, and KFHP-NG-KPIF-MD for Maryland residents), which you will receive upon acceptance. Please call Member Services at (301) 468-6000 or 1-800-777-7902 for additional assistance.

Meet the Howards

Vera and Joe Howard are in their early 50s.¹ When Vera is laid off, Joe takes a buyout so they can enjoy early retirement. So now, after years of group coverage, they're looking for an individual health care plan.

The Howards want to minimize their health care costs, so they enroll in an HSA-qualified deductible plan, the \$1,250 Deductible/20% Plan with HSA Option.

- **Their HSA:** Joe opens an HSA with Wells Fargo and deposits the federal family maximum of \$6,150, which he can deduct from his federal income tax.^{2,3} Any interest that the HSA earns is tax free. Plus, the couple can withdraw funds tax free to pay for qualified medical expenses.
- **Meeting the deductible:** The couple must pay full charges until they meet the \$2,500 family deductible. They simply present their HSA Visa debit card when they receive services, and the payments are automatically deducted from the tax-deductible \$6,150 that Joe had deposited into their HSA.
- **Preventive care:** Joe and Vera each get annual checkups. Their physicals are no charge and are not subject to the deductible, because they are preventive care. Vera also gets a mammogram, which is also no charge and not subject to the deductible.
- **Treatment:** Vera's mammogram detects an irregularity that requires treatment. Over the year, her medical bills total \$50,000. They pay the first \$2,500 (their deductible) from their HSA. Then they are eligible to pay a copay or coinsurance for covered services until they meet the \$6,000 family OOPM.



- **Meeting the out-of-pocket maximum (OOPM):** With the Howards' HSA-qualified plan, their \$2,500 family deductible applies toward their \$6,000 OOPM. After they pay \$3,500 in copayments and coinsurance, they meet the family OOPM. Now neither of them has to pay anything for covered medical expenses for the rest of the contract year.
- **Tax savings:** They only pay \$6,000 of the \$50,000 in medical bills out of pocket—and those payments are in tax-deductible dollars. At the end of the year, the remaining \$150 in their HSA rolls over to the next year.

Vera feels fortunate that her Kaiser Permanente doctor urged her to get a mammogram. It ensured her good health for years to come.

¹This example is for illustrative purposes only. Individual situations will vary depending on the specifics of the health care plan.

²For 2010, the federally established maximum contribution for an eligible individual with self-only coverage is \$3,050, and the annual maximum contribution for an eligible individual with family coverage is \$6,150. This annual maximum is indexed annually for inflation. For more information, please consult your financial or tax adviser.

³Tax savings refer to federal income tax only.

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES EXCLUSIONS AND LIMITATIONS

The following list contains exclusions and limitations associated with the benefits shown in the following documents: plan overview, copayment plans, deductible plans, and HSA-qualified deductible plans.

Preventive care

Limitations:

While the following services may be provided during the course of a preventive care visit, the following services are not considered preventive care: monitoring of chronic disease; diagnosis, followup, services provided to treat a specific disease, and non-routine gynecological visits.

Emergency services

Limitations:

The member or someone on the member's behalf must notify us as soon as possible, but no later than 48 hours or the next business day, whichever is later, of the hospital admission unless it was not reasonably possible to notify us. Follow-up care at a non-plan hospital must be authorized by the Health Plan.

Urgent Care services

Limitations:

We do not cover services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require services while outside our Service Area, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

Ambulance services

Exclusions:

Transportation by any type of transportation other than a licensed ambulance.

Vision care

Exclusions:

- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
- Eye exercises.
- Orthoptic (eye training) therapy.
- Sunglasses without corrective lenses unless medically necessary.
- Contact lens services other than the initial fitting and purchase of contact lenses as provided in this section.
- Non-corrective contact lenses.
- Replacement of lost or broken lenses or frames.

HSA-qualified deductible (1250, 1750, 2500 deductible levels) and deductible (4500, 8000 deductible levels) plan exclusions:

- Exclusions noted above plus,
- Eyeglass lenses and eyeglass frames, and
- All services related to contact lenses, including examinations, fitting and dispensing, and follow-up visits, except as otherwise noted.

Prescription drugs (up to 30-day supply, if applicable)

Exclusions:

Drugs, supplies, and supplements exclusions:

- Drugs, supplies, and supplements that can be self-administered or do not require administration or observation by medical personnel.
- Drugs for which a prescription is not required by law, except if the drug is approved under our preferred drug list guidelines.
- Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes.
- Replacement prescriptions necessitated by theft or loss.
- Prescribed drugs and accessories that are necessary for services that are excluded under this agreement.
- Drugs to shorten the duration of the common cold.
- Special packaging (e.g., blister pack, unit dose, or unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription medications.
- Alternative formulations or delivery methods that are (1) different from the Health Plan's standard formulation or delivery method for prescription drugs and (2) deemed not medically necessary.
- Diabetic equipment and supplies, which are covered under Section 3 of this agreement.
- Drugs for treatment of sexual dysfunction disorder.

Limitations:

Benefits are subject to the following limitations:

- For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our preferred drug list and purchased at a plan pharmacy.
- In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department.

Dental services

Exclusions:

The following services are not covered under your dental plan:

- Services provided by dentists or other practitioners of healing arts not associated with the Health Plan and/or dental administrator except upon referral arranged by a participating dental provider and authorized by us, or when required in a covered emergency.
- Services for injuries or conditions which are covered under worker's compensation and/or employer's liability laws.
- Services that are provided without cost to members by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid).
- Services that, in the opinion of the attending dentist, are not necessary for the patient's dental health.
- Cosmetic or aesthetic dentistry.

- Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan as described in Section 3 of the agreement.
- Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan as described in Section 3 of the agreement.
- Hospitalization for any dental procedure.
- Treatment required for conditions resulting from major disaster, epidemic, or war, including declared or undeclared war or acts of war.
- Replacement due to loss or theft of prosthetic appliance.
- Services that cannot be performed because of the general health of the patient.
- Implantation and related restorative procedures.
- Services not listed as covered dental services in the list of covered dental services provided by dental administrator.
- Services provided by a non-participating dental provider or not pre-authorized by dental administrator (with the exception of out-of-area emergency dental services).
- Services related to the treatment of TMD (temporomandibular disorder).
- Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth.
- Dental expenses incurred in connection with any dental procedure that was started prior to your effective date of coverage under this dental plan and agreement. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
- Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan described in the agreement.
- Treatment of malignancies, neoplasm, or congenital malformations, except as may be otherwise covered in your medical plan as described in the agreement.
- Experimental procedures, implantations, or pharmacological regimens.

Limitations:

Covered dental services are subject to the following limitations:

- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed.
- Replacement of a filling within two (2) years after original date of placement.
- Coverage for periodic oral exams, prophylaxes (cleanings), and fluoride applications is limited to once every six (6) months.
- Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's usual, customary, and reasonable (UCR) fee, minus 25 percent.
- Full mouth X-rays or panoramic film is limited to one set every three (3) years.
- Retreatment of root canal within two (2) years of the original treatment.
- Coverage for sealants is limited to the first and second permanent molars for children under the age of 16 once every 24 months.
- Coverage for periodontal surgery of any type, including any associated material is covered once every 36 months per quadrant or surgical site.
- Coverage for root planing or scaling is limited to once every 24 months per quadrant.
- Full mouth debridement is limited to once every 36 months.
- Periodontal maintenance after active therapy is limited to twice per 12 months within 24 months after definitive periodontal therapy.
- Coverage for relining of dentures is limited to once every 12 months.


To request a full list of Exclusions and Limitations please call member services at 301-468-6000 or 1-800-777-7902 (TTY 301-879-6380), Monday through Friday, 7:30 a.m.–5:30 p.m.

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