



2006 benefits summary for:

**Kaiser Permanente for Individuals and Families  
\$20 Plan**

	Member pays
<b>Deductible and lifetime maximum</b>	None
<b>Annual supplemental charges maximum per calendar year for "basic health services"</b>	\$1,500 per member \$4,500 per family unit (3 or more members)
<b>Preventive services</b>	
<b>Office visit for well baby checks</b>	\$20 per visit
<b>Immunizations</b>	No charge for most immunizations (some have a 50% copayment)
<b>Office visit for physicals</b> routine and school	\$20 per visit, plus 50% lab, imaging, and testing charges
<b>Outpatient services</b>	
<b>Office visits</b> doctors' & other health professionals'	\$20 per visit
<b>Lab, imaging, and testing</b>	50% of applicable charges
<b>Outpatient surgery and procedures</b>	\$20 per visit
<b>Routine obstetrical care</b> routine scheduled prenatal visits, uncomplicated delivery, routine postpartum visit	\$500 upon confirmation of pregnancy
<b>Abortions</b> elective or medically indicated	\$200 per abortion (elective abortions limited to two per lifetime)
<b>Administered drugs</b>	No charge for most drugs that require skilled administration by medical personnel. Members must pay their office visit copay for the visit.
<b>Prescription/self administered drugs</b> such as those taken orally	Not covered
<b>FDA-approved contraceptive drugs and devices to prevent unwanted pregnancy</b>	50% of applicable charges
<b>Inpatient services</b>	
<b>Hospital (room and board)</b>	\$200 per hospital day (does not apply to mother's routine maternity hospital days after delivery of baby)
<b>Inpatient stay (room and board) for newborn</b>	\$200 per hospital day during or after mother's hospital stay
<b>Doctors' medical and surgical services</b>	No charge
<b>Anesthesia services</b>	No charge
<b>Lab, imaging, and testing</b>	50% of applicable charges
<b>Administered drugs</b>	No charge for most drugs administered during a covered hospital stay
<b>Skilled nursing care</b>	No charge up to 60 days per benefit period
<b>Mental health services</b>	
<b>Outpatient</b> up to 24 visits/calendar year	20% of applicable charges
<b>Inpatient</b> up to 30 days/calendar year	20% of applicable charges
<b>Chemical dependency services</b>	
<b>Outpatient</b>	\$20 per visit
<b>Inpatient</b>	\$200 per hospital day
<b>Residential</b>	20% of applicable charges up to 60 days per calendar year
<b>Emergency services (for initial treatment only) &amp; ambulance services</b>	
<b>At a facility within the Hawaii service area</b>	\$50 per visit, plus other applicable plan charges
<b>At a facility outside the Hawaii service area</b>	20% of applicable charges, plus other applicable plan charges
<b>Ambulance services</b>	20% of applicable charges, plus any charges above applicable charges
<b>All care and services need to be coordinated by a Kaiser Permanente physician</b>	
<b>Dependent coverage up to age 19</b>	Unmarried dependent children are covered up to their 19 <sup>th</sup> birthday
<b>Student coverage up to age 25</b>	Unmarried dependent children who are full-time students and have the same legal address as the subscriber are covered up to their 25 <sup>th</sup> birthday

This is only a summary. It does not fully describe your benefit coverage. For more details on your benefit coverage, exclusions, limitations, and plan terms, or for information on our drug formulary, practitioner and provider availability, please refer to the Kaiser Permanente for Individuals and Families Plan Member handbook, which you may obtain by calling our Customer Service Center at 432-5955 (Oahu), 1-800-966-5955 (Neighbor Islands), or 1-877-447-5990 (TTY for the hearing and speech impaired).

## Exclusions

When a Service is excluded or non-covered, all Services that are necessary or related to the excluded or non-covered Service are also excluded. "Service" means any treatment, diagnosis, care, therapeutic or diagnostic procedure/test, drug, injectable, facility, equipment, item, device, or supply.

The following Services are excluded:

### **Acupuncture.**

**Alternative medical Services** not accepted by standard allopathic medical practices such as: hypnotherapy, behavior testing, sleep therapy, biofeedback, massage therapy, naturopathy, rest cure and aroma therapy.

**Artificial aids**, such as eyeglasses, corrective lenses and hearing aids.

**All blood, blood products, blood derivatives, and blood components** whether of human or manufactured origin and regardless of the means of administration, except as stated under the Blood section. Donor directed units are not covered.

### **Cardiac rehabilitation.**

### **Chiropractic Services.**

Services for **confined members** (confined in criminal institutions, or quarantined).

**Contraceptive foams and creams, condoms** or other non-prescription substances used individually or in conjunction with any other prescribed drug or device.

**Corrective aids and appliances**, such as orthotics.

**Cosmetic Services**, such as plastic surgery to change physical appearance, which will not result in significant improvement in physical function. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery or incident to a covered mastectomy are covered.

### **Custodial Services or Services in an intermediate level care facility.**

**Dental care Services** such as dental x-rays, dental implants, dental appliances, or orthodontia and Services relating to temporomandibular joint dysfunction (TMJ) or Craniomandibular Pain Syndrome.

**Durable medical equipment**, such as crutches, canes, oxygen-dispensing equipment, hospital beds and wheelchairs used in the member's home (including an institution used as his or her home), except diabetes glucose meters and external insulin pumps for non-Medicare members.

**Employer or government responsibility:** Services that an employer is required by law to provide or that are covered by Worker's Compensation or employer liability law; Services for any military service-connected illness, injury or condition when such Services are reasonably available to the member at a Veterans Administration facility; Services required by law to be provided only by, or received only from, a government agency.

### **Experimental or investigational Services.**

**External prosthetic devices**, such as artificial limbs.

**Eye examinations** for contact lenses and **eye exercises.**

**Routine foot care**, unless medically necessary.

**Health education** - specialized health promotion classes and support groups (such as the bariatric surgery program).

### **Homemaker Services.**

The following costs and Services for **infertility services, in vitro fertilization or artificial insemination:**

- The cost of equipment and of collection, storage and processing of sperm.
- In vitro fertilization using either donor sperm or donor eggs.
- In vitro fertilization that does not meet state law requirements.
- Services related to conception by artificial means other than artificial insemination or in vitro fertilization, such as ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), including prescription drugs related to such Services and donor sperm and donor eggs used for such Services.
- Services to reverse voluntary, surgically-induced infertility.

The following **mental health** costs and Services:

- Services that, in the opinion of a Kaiser Permanente physician, are not necessary or reasonably expected to improve the member's condition.
- Continuation in a course of treatment for members who are disruptive or physically abusive.
- Services on court order or as a condition of parole or probation unless determined by a Kaiser Permanente physician to be medically necessary and appropriate.
- Testing or treatment requested or required by a non-Kaiser Permanente outside agency/body, in connection with administrative or court proceedings (such as divorce or child custody proceedings), hearings, gun permit applications, employment or disability matters, unless the test or treatment is determined by a Kaiser Permanente physician to be medically necessary and appropriate.
- Testing for ability, aptitude, intelligence, learning disability or interest.
- Occupational therapy supplies.
- Mental Health Services for mental retardation, after diagnosis.

The following **residential chemical dependence** costs and Services:

- Services that, in the opinion of a Kaiser Permanente physician, are not necessary or reasonably expected to improve the member's condition.
- Continuation in a course of treatment for members who are disruptive or physically abusive.
- Services on court order or as a condition of parole or probation unless determined by a Kaiser Permanente physician to be medically necessary and appropriate.
- Testing or treatment requested or required by a non-Kaiser Permanente outside agency/body, in connection with administrative or court proceedings (such as divorce or child custody proceedings), hearings, gun permit applications, employment or disability matters, unless the

test or treatment is determined by a Kaiser Permanente physician to be medically necessary and appropriate.

- Occupational therapy supplies.

**Certain exams and Services.** Certain Services, and related reports/paperwork, in connection with third party requests, such as those for: employment, participation in employee programs, sports, camp, insurance, disability, licensing, or on court-order or for parole or probation. Physical examinations that are authorized and deemed medically necessary by a Kaiser Permanente physician and are coincidentally needed by a third party are covered according to the member's benefits.

**Radial keratotomy (RK), Photo-refractive keratectomy (PRK),** and similar procedures.

Long term **physical therapy, occupational therapy, speech therapy;** maintenance therapies; physical, occupational, and speech therapy deficits due to developmental delay; therapies not expected to result in significant, measurable improvement in physical function with short-term therapy.

**Services not generally and customarily available in the Hawaii service area.**

**Services and supplies not medically necessary.** A service or item is medically necessary (in accord with medically necessary state law definitions and criteria) only if, 1) recommended by the treating Kaiser Permanente physician or treating Kaiser Permanente licensed health care practitioner, 2) is approved by Kaiser Permanente's medical director or designee, and 3) is for the purpose of treating a medical condition, is the most appropriate delivery or level of service (considering potential benefits and harms to the patient), and known to be effective in improving health outcomes. Effectiveness is determined first by scientific evidence, then by professional standards of care, then by expert opinion. Coverage is limited to the services which are cost effective and adequately meet the medical needs of the member.

All Services, drugs, injections, equipment, supplies and prosthetics related to treatment of **sexual dysfunction**, except evaluations and health care practitioners' services for treatment of sexual dysfunction.

All Services, drugs, prosthetics, devices or surgery related to **gender re-assignment**.

**Take home supplies** for home use, such as bandages, gauze, tape, antiseptics, ace type bandages, drug and ostomy supplies, catheters and tubing, except Medicare covered take home supplies for Medicare members.

The following costs and Services for **transplants**:

- Non-human and artificial organs and their transplantation.

- Bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tissue tumors, except for germ cell tumors and neuroblastoma in children.

Services for injuries or illness caused or alleged to be caused by **third parties or in motor vehicle accidents**.

**Transportation** (other than covered ambulance services), **lodging, and living expenses.**

Oral **travel immunizations.**

**Services for which coverage has been exhausted, Services not listed as covered, or excluded Services.**

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## Limitations

Benefits and Services are subject to the following limitations:

Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.

Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when Kaiser Permanente physicians believe no professionally acceptable alternative treatment exists. Coverage will be provided up to the point that the member followed the recommended treatment.

**Residential chemical dependence treatment Services** are limited to two (2) treatment episodes per lifetime.

When members are covered for **contraceptive drugs and devices**, they only covered only when the prescription drugs meet all of the following criteria: 1) prescribed by a licensed Prescriber, 2) the drug is one for which a prescription is required by law, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc.

**Internally implanted prosthetics, devices, and aids** (such as pacemakers, hip joints, surgical mesh, stents, bone cement, bolts, screws, and rods), **Durable medical equipment, and External Prosthetics and Braces** (if you have coverage for them) are subject to Medicare coverage guidelines and limitations.

**Diabetes equipment** and supplies necessary to operate them are subject to Medicare coverage guidelines and limitations, must be preauthorized in writing by Kaiser Permanente, and obtained from a Health Plan designated vendor.

Short-term **physical, occupational and speech therapy Services** means medical services provided for those conditions which meet all of the following criteria: a) the therapy is ordered by a Physician under an individual treatment plan; b) in the judgment of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy; c) The therapy is provided by or under the supervision of a Physician-designated licensed physical, speech, or occupational therapist, as appropriate.; and d) As determined by a Physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury.

Neurological and/or musculoskeletal function is sufficient when one of the following **first** occurs: i) neurological and/or musculoskeletal function is the level of the average healthy person of the same age, ii) further significant functional gain is unlikely, or iii) the frequency and duration of therapy for a specific medical condition as specified in Kaiser Permanente Hawaii's Clinical Practice Guidelines has been reached.. Occupational therapy is limited to hand rehabilitation services, and medical services to achieve improved self care and other customary activities of daily living. Speech-language pathology is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin.

**Tuberculin skin test** is limited to one per calendar year, unless medically necessary.

Donor's **transplant** expenses. Health Plan will pay for health care services for living organ and tissue donors and prospective donors if the services meet all of the following requirements. Health Plan pays for these services as a courtesy to donors and prospective donors, and this

document does not give donors or prospective donors any of the rights of Health Plan members.

- The terms, conditions, and Supplemental Charges of the Kaiser Permanente member transplant recipient will apply to the donor.
- The services required are directly related to a covered transplant for a Health Plan member and required for a) screening of potential donors, b) harvesting the organ or tissue, or c) treatment of complications resulting from the donation.
- For services to treat complications, the donor receives the services from Kaiser Permanente practitioners inside a Health Plan Region or Group Health service area.
- Health Plan will pay for emergency services directly related to the covered transplant that a donor receives from non-Kaiser Permanente practitioners to treat complications.
- The services are provided not later than three months after donation.
- The services are provided while the transplant recipient is still a Member, except that this limitation will not apply if the Member's membership terminates because he or she dies.
- Health Plan will not pay for travel or lodging for donors or prospective donors.
- Health Plan will not pay for services if the donor or prospective donor is not a Kaiser Permanente member and is a member under another health insurance plan, or has access to other sources of payment.
- The above guidelines do not apply to blood donors.