Kaiser Permanente for Individuals and Families Platinum Plan
2008 Benefits summary

(This is not a federally qualified health benefit plan)

This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your applicable Kaiser Permanente for Individuals and Families Non-Group Medical and Hospital Service Agreement, benefit schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control.

You are covered for medically necessary services, within the Hawaii service area, at Kaiser Permanente facilities, and which are provided or arranged by a Kaiser Permanente physician. All care and services need to be coordinated by a Kaiser Permanente physician.

Unless explicitly described in a particular benefit section (e.g. physical therapy is explicitly described under the hospice benefit section), each medical service or item is covered in accord with its relevant benefit section. For example, drugs or laboratory services related to in vitro fertilization are not covered under the in vitro fertilization benefit. Drugs related to in vitro fertilization are covered under the prescribed drugs benefit section. Laboratory services related to in vitro fertilization are covered under the laboratory services benefit section.

Section	Benefits	You pay
Outpatient services	**Primary care and specialty care office visits** (office visits are limited to one or more of the following services: exam, history, medical decision making) †	$20 per visit (limited to 5 office visits per calendar year)
	Outpatient surgery and procedures	$20 per visit
	Preventive care office visits for: • Health evaluations for adults † • Physical examinations for children † • Well baby care (counts toward the 5 office visit limit per calendar year except as required by Hawaii state law during the first year for birth, and ages 2 months, 4 months, 6 months, 9 months, and 12 months) • Eye examinations for eyeglasses * † • Ear examinations to determine the need for hearing correction †	$20 per visit
	Routine immunizations [1]	
	• For children 18 years of age and under on the date the immunization is administered [2]	No charge
	• For adults 19 years of age and over on the date the immunization is administered	$10 per dose
	Influenza and pneumococcal immunizations [1]	No charge
	Unexpected mass immunizations [1]	50% of applicable charges
	Laboratory services, imaging services, and testing services	50% of applicable charges
	Short-term physical, occupational and speech therapy ** † (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply)	$20 per visit

[1] *Immunizations (routine, influenza, pneumococcal, and unexpected mass) for prevention of disease must meet all of the following criteria:*
- *Recommended by the Advisory Committee on Immunization Practices (ACIP),*
- *Published in the Morbidity and Mortality Weekly Report (MMWR) by the Centers for Disease Control and Prevention (CDC) in accordance with published criteria, guidelines, or restrictions, and*
- *On the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions.*

[2] *Includes routine immunizations (in keeping with "prevailing medical standards" as defined by state law) for children 5 years of age and under*

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▼ Members must pay their office visit copay for the office visit.
* See **Coverage Exclusions** Section
** See **Coverage Limitations** Section

Section	Benefits	You pay
Outpatient services (continued)	**Dialysis †**	
	• Kaiser Permanente physician and facility services for dialysis	$20 per visit
	• Equipment, training and medical supplies for home dialysis	No charge
	Materials for dressings and casts	No charge
Hospital inpatient care (for acute care registered bed patients)	**Hospital inpatient care** includes services such as: • Room and board • General nursing care and special duty nursing • Physicians' services • Surgical procedures • Respiratory therapy and radiation therapy • Anesthesia • Medical supplies • Use of operating and recovery rooms • Intensive care room	$200 per day
	Short-term physical, occupational and speech therapy ** (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply)	Included in the above hospital inpatient care copay
	Laboratory services, imaging services, and testing services	50% of applicable charges
	Materials for dressings and casts	No charge
Transplants	**Transplants**, including kidney, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel, and small bowel-liver transplants *** †**	See applicable benefit sections (e.g. – office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.)
Preventive screening services †	**Preventive screening services** which meet Kaiser Permanente Prevention Committee's average risk guidelines are limited to the services listed below: • Anemia and lead screening for children • Colorectal cancer screening • Chlamydia detection • Fecal occult blood test • Lipid evaluation • Newborn metabolic screening • Cervical cancer screening • Screening mammography • Osteoporosis screening	No charge; member pays $20 for office visit if applicable
Prescribed drugs †	**Prescribed drugs that require skilled administration by medical personnel** (e.g. cannot be self-administered) which meet all of the following: • Prescribed by a Kaiser Permanente licensed prescriber, • On the Health Plan formulary and used in accordance with formulary criteria, guidelines or restrictions, and • Prescription is required by law	No charge ▼
	Immunizations are described in the outpatient services section	
	Contraceptive drugs and devices are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section	
	Exclusions: • Drugs that are necessary or associated with services that are excluded or not covered	

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Section	Benefits	You pay
Obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services	**Obstetrical (maternity) care** • All maternity care is not covered (such as prenatal visits, delivery/hospital stay, post-partum visits, related labs, diagnostic imaging etc.)	All charges (maternity care is not covered)
	Inpatient stay and inpatient care for newborn during or after mother's hospital stay (assuming newborn is timely enrolled on Kaiser Permanente subscriber's plan)	Hospital inpatient care benefits apply (see hospital inpatient care section)
	Interrupted pregnancy • Medically indicated abortions • Elective abortions (including abortion drugs such as RU-486) limited to two per member per lifetime	 $200 per abortion $200 per abortion
	Family planning office visits †	$20 per visit
	FDA approved contraceptive drugs and devices ** (to prevent unwanted pregnancies) †	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply) ▼
	Involuntary infertility office visits †	$20 per visit
	Artificial insemination * †	$20 per visit
	In vitro fertilization * • Limited to one-time only benefit at Kaiser Permanente • Limited to female members using spouse's sperm	20% of applicable charges
Home health care and hospice care	**Home health care**, nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	No charge
	Hospice care. Supportive and palliative care for a terminally ill member, as directed by a Kaiser Permanente physician. Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. The member must be certified by a Kaiser Permanente physician as terminally ill at the beginning of each period. (Hospice benefits apply in lieu of any other plan benefits for treatment of terminal illness.) Hospice includes services such as: • Nursing care (excluding private duty nursing) • Medical social services • Home health aide services • Medical supplies • Kaiser Permanente physician services • Counseling and coordination of bereavement services • Services of volunteers • Physical therapy, occupational therapy, or speech language pathology	No charge
Skilled nursing care	Up to **60 days of prescribed skilled nursing care services in an approved facility** (such as a hospital or skilled nursing facility) **per benefit period**. Covered services include nursing care, room and board, medical social services, medical supplies, and durable medical equipment ordinarily provided by a skilled nursing facility. In addition to Health Plan criteria, Medicare guidelines are used to determine when skilled nursing services are covered, except that a prior three-day stay in an acute care hospital is not required. **Exclusions:** Personal comfort items, such as telephone, television and take-home medical supplies.	No charge

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Section	Benefits	You pay
Emergency services ▲ (covered for initial emergency treatment only)	At a facility within the Hawaii service area for covered emergency services	$50 copay per visit
	At a facility outside the Hawaii service area for covered emergency services	20% of applicable charges
	Note: Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility.	
	▲ *Emergency Services are those medically necessary services that meet the prudent layperson standard and were immediately required due to sudden and unforeseen illness/injury. In addition, in cases where care is received from non-Kaiser Permanente physicians, covered emergency services are only those where receipt of services from a Kaiser Permanente physician would have entailed a delay resulting in death, serious impairment to bodily functions, serious dysfunction of any bodily organ, or placing the health of the individual in serious jeopardy.* ***Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.***	
Out-of-area urgent care services (while temporarily outside the Hawaii service area)	At a non-Kaiser Permanente facility for covered urgent care services (Coverage for initial urgent care treatment only) ❖	20% of applicable charges
	❖ *"Urgent Care Services" means initial care for a sudden and unforeseen illness or injury when the member is TEMPORARILY away from the Hawaii service area, which is required to prevent serious deterioration of the member's health and which cannot be delayed until the member is medically able to safely return to the Hawaii service area or travel to a Kaiser Permanente facility in another Health Plan Region.* ***Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.***	
Ambulance services	Ambulance Services are those services in which: • Use of any other means of transport, regardless of availability of such other means, would result in death or serious impairment of the member's health, and • Is for the purpose of transporting the member to receive medically necessary acute care. In addition, air ambulance must be for the purpose of transporting the Member to the nearest medical facility designated by Health Plan for receipt of medically necessary acute care, and the member's condition must require the services of an air ambulance for safe transport.	20% of applicable charges
Blood	Regardless of replacement, units and processing of units of **whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin**	20% of applicable charges
	Collection, processing, and storage of **autologous blood** when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used	20% of applicable charges

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Section	Benefits	You pay
Mental health services * for serious mental illness	"Serious mental illness" includes schizophrenia, schizo-affective disorder, bipolar types I and II, delusional disorder, major depression, obsessive-compulsive disorder.	
	Outpatient office visits	$20 per visit
	Hospital inpatient care	$200 per day
Mental health services * for non-serious mental illness	**Up to 24 outpatient office visits per calendar year**	20% of applicable charges
	• Psychological testing ***** as part of diagnostic evaluation, when ordered by a Kaiser Permanente physician or psychologist	20% of applicable charges
	Additional outpatient office visits Each day of inpatient hospital service may be exchanged for two days of outpatient visits, provided that the member's condition is such that the outpatient services would reasonably preclude hospitalization	20% of applicable charges
	Up to 30 days of hospital care per calendar year Coverage under mental health benefits can include any combination of hospital days and specialized facility services. (Two (2) days of specialized facility care counts as one (1) hospital day.)	
	• Hospital care Services of Kaiser Permanente physicians, mental health professionals and other health care professionals, or Kaiser Permanente physician's visits in specialized facility	20% of applicable charges
	• Specialized facility services Non-hospital residential services, partial hospitalization services or day treatment services in a specialized mental health treatment unit or facility approved by Kaiser Permanente Medical Group	20% of applicable charges
Chemical dependency services **	Outpatient office visits	$20 per visit
	Hospital inpatient care	$200 per day
	Up to 60 days per calendar year of residential chemical dependency services *****	20% of applicable charges
Internal prosthetics, devices, and aids	**Implanted internal prosthetics** (such as pacemakers and hip joints), **and internally implanted devices and aids** (such as surgical mesh, stents, bone cement, implanted nuts, bolts, screws, and rods) which are prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan	50% of applicable charges
	Fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss	50% of applicable charges
	Internal prosthetics are those which meet all of the following criteria: • Are required to replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ, • Are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA), • Were in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, and • Are not excluded from coverage from Medicare, and if covered by Medicare, meet the coverage definitions, criteria and guidelines established by Medicare at the time the device is prescribed.	
	Exclusions: • All implanted internal prosthetics and devices and internally implanted aids related to an excluded or non-covered service/benefit • Prosthetics, devices, and aids related to sexual dysfunction	
	Limitations: • Coverage is limited to the standard prosthetic model that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.	

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Section	Benefits	You pay
Diabetes equipment	**Diabetes equipment** (limited to glucose meters and external insulin pumps, and the supplies necessary to operate them) which are prescribed by a Kaiser Permanente physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan **Diabetes equipment** is that equipment and supplies necessary to operate the equipment which: • Is intended for repeated use, • Is primarily and customarily used to serve a medical purpose, • Is appropriate for use in the home, • Is generally not useful to a person in the absence of illness or injury, • Was in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, • Is not excluded from coverage from Medicare, and if covered by Medicare, meets the coverage definitions, criteria and guidelines established by Medicare at the time the diabetes equipment is prescribed, and • Is on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions. **Exclusions:** • Comfort and convenience equipment, and devices not medical in nature. • Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages. • Repair, adjustment or replacement due to misuse or loss. • Experimental or research equipment. **Limitations:** • If rented or loaned from Health Plan, the Member must return any diabetes equipment items to Health Plan or its designee or pay Health Plan or its designee the fair market price for the equipment when it is no longer prescribed by a Physician or used by the Member. • Coverage is limited to the standard item of diabetes equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)
Dependent coverage up to age 19	Unmarried dependent (biological, step or adopted) children of the Subscriber (or the Subscriber's spouse) are eligible up to the child's 19th birthday. Other unmarried dependents may include: • The Subscriber's (or Subscriber's spouse's) dependent (biological, step or adopted) children (over age 19) who are incapable of self-sustaining employment by reason of mental retardation or physical handicap, and are chiefly dependent upon the Subscriber (or Subscriber's spouse) for support and maintenance (proof of incapacity and dependency may be required). • A person who is under age 19, is living in a parent-child relationship with the Subscriber (or Subscriber's spouse) is entirely supported by the Subscriber (or Subscriber's spouse), is permanently living in the Subscriber's household, and for whom the Subscriber (or Subscriber's spouse), is (or was before the person's 18th birthday) the court appointed legal guardian.	
Student coverage up to age 25	Unmarried dependent (biological, step or adopted) children who are full-time students pursuing a license, degree or professional certification at a state recognized and duly accredited school or university and have the same legal address as the Subscriber are eligible up to the child's 25th birthday. To qualify for this coverage, the Subscriber must fill out a Student Certification Form for each eligible dependent and return it to Kaiser Permanente. This information is subject to prior verification by Kaiser Permanente.	

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Section	Benefits	You pay
Supplemental charges maximum	**Your out-of-pocket expenses for covered Basic Health Services are capped each year by a supplemental charges maximum.**	$2,000 per member, $6,000 per family unit (3 or more members), for calendar year

YOU MUST RETAIN YOUR RECEIPTS for these supplemental charges and when that maximum amount has been **PAID**, present these receipts to our Business Office at Moanalua Medical Center, Honolulu, Waipio, or Wailuku Clinics, or to the cashier at other clinics. After verification that the supplemental charges maximum has been **PAID, you will be given a card** which indicates that no additional supplemental charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to **show this card** at your visits to ensure no additional supplemental charges are billed or collected for the remainder of the calendar year in which the medical services were received. **All payments are credited toward the calendar year in which the medical services were received.**

You will be provided an updated status about which of your payments may be applied to the supplemental charges maximum. Please allow a minimum of 10 working days to verify that your supplemental charge maximum has been met.

Note: Once you have met the supplemental charges maximum, please submit your proof of payment as soon as reasonably possible. All receipts must be submitted no later than February 28 of the year following the one in which the medical services were received.

Supplemental charges for the following covered Basic Health Services can be applied toward the supplemental charges maximum: your 5 covered office visits for medical services listed in this Basic Health Services section, ambulance service, artificial insemination, chemical dependency services (except residential services), dialysis, drugs requiring skilled administration, emergency service, family planning office visits, health evaluation office visits for adults, home health, imaging (including X-rays), immunizations (excluding travel immunizations), in vitro fertilization procedure (excluding drugs), infertility office visits, inpatient room (semi-private), interrupted pregnancy/abortion, laboratory, mental health services for the first 24 outpatient visits and the first 30 inpatient visits, outpatient surgery and procedures, radiation and respiratory therapy, reconstructive surgery, short-term physical therapy, short-term speech therapy, short-term occupational therapy, testing services, transplants (the procedure), and urgent care.

These are not Basic Health Services and charges for these services/items are ***not*** applicable towards the supplemental charges maximum: all services for which coverage has been exhausted (such as office visits over the five office visit limit), all excluded or non-covered benefits (such as obstetrical (maternity) care), all other services not specifically listed above as a Basic Health Service, allergy test materials, blood or blood processing, braces, complementary alternative medicine (chiropractic, acupuncture, or massage therapy), contraceptive drugs and devices, dental services, diabetes supplies and equipment, dressings and casts, durable medical equipment, external prosthetics, handling fee or taxes, health education services, classes or support groups, hospice, internal prosthetics, internal devices and aids, medical foods, medical social services, mental health services after the first 24 outpatient visits and the first 30 inpatient visits, office visits for services which are not Basic Health Services, orthopedic devices, radioactive materials, residential chemical dependency services, self administered/outpatient prescription drugs, skilled nursing care, take-home supplies, and travel immunizations.

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* Coverage 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, procedure, test, drug, injectable, facility, equipment, item, device, or supply. The following Services are excluded:

- **Obstetrical (maternity) Services**, such as prenatal visits, delivery/hospital stay, post-partum visits, and related labs and diagnostic imaging.
- **Acupuncture**. (This exclusion may not apply if you have the applicable Complementary Alternative Medicine Rider.)
- **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. (The massage therapy portion of this exclusion may not apply if you have the applicable Complementary Alternative Medicine Rider.)
- **Artificial aids, corrective aids and corrective appliances** such as external prosthetics, braces, orthopedic aids, orthotics, hearing aids, corrective lenses and eyeglasses. (The eyeglasses and contact lens portion of this exclusion may not apply if you have an Optical Rider. The external prosthetic devices and braces portion of this exclusion may not apply if you have an External Prosthetic Devices and Braces Rider.)
- **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**. (This exclusion may not apply if you have the applicable Complementary Alternative Medicine Rider.)
- 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.
- **Cosmetic services**, such as plastic surgery to change or maintain physical appearance, which is not likely to 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. (Part of this exclusion may not apply if you have a Dental Rider.)
- **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. (This exclusion does not apply if you have a Durable Medical Equipment Rider.)
- **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 Affairs facility; Services required by law to be provided only by, or received only from, a government agency.
- **Experimental or investigational Services**.
- **Eye examinations** for contact lenses (Eye exams for contact lens may be partially covered if you have an Optical Rider.) 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.
- **Non FDA-approved drugs and devices.**
- **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.
- 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**.
- **Travel immunizations**.
- **Services for which coverage has been exhausted, Services not listed as covered, or excluded Services.**

** Coverage 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 cease at the point the member stops following the recommended treatment.
- **Chemical dependence treatment Services** are limited to two (2) treatment episodes per lifetime. (Exception: If you have the Mental Health Rider U, chemical dependence treatment Services are limited to three (3) treatment episodes per lifetime.)
- Members are covered for **contraceptive drugs and devices** 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** (if you have a Durable Medical Equipment Rider), and **external prosthetics and braces** (if you have an External Prosthetic Devices and Braces Rider) 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.
- **Transplant** services for transplant donors. Health Plan will pay for medical services for living organ and tissue donors and prospective donors if the medical services meet all of the requirements below. Health Plan pays for these medical 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.
  - Regardless whether the donor is a Kaiser Permanente member or not, the terms, conditions, and Supplemental Charges of the transplant-recipient Kaiser Permanente member will apply. Supplemental charges for medical services provided to transplant donors are the responsibility of the transplant-recipient Kaiser Permanente member to pay, and count toward the transplant-recipient Kaiser Permanente member's limit on supplemental charges.
  - The medical services required are directly related to a covered transplant for a Kaiser Permanente 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 medical services to treat complications, the donor receives the medical 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 medical services are provided not later than three months after donation.
  - The medical services are provided while the transplant-recipient is still a Kaiser Permanente member, except that this limitation will not apply if the Kaiser Permanente 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 medical 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 policy does not apply to blood donors.
- **Office visits limited to 5 per calendar year,** other than state law required.

Third party liability, motor vehicle accidents, and surrogacy health services

Kaiser Permanente has the right to recover the cost of care for a member's injury or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the member by an insurance company, individual or other third party.

Kaiser Permanente has the right to recover the cost of care for Surrogacy Health Services. Surrogacy Health Services are Services the Member receives related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement. The Member must reimburse Kaiser Permanente for the costs of Surrogacy Health Services, out of the compensation the Member or the Member's payee are entitled to receive under the Surrogacy Arrangement.

	Benefits	You pay
Drug benefit 15 for Platinum Plan	**For each prescription, when the quantity does not exceed:** • a 30–consecutive-day supply of a prescribed drug, or • an amount as determined by the formulary.	$15 per prescription
	Self-administered drugs are covered only when all of the following criteria are met: • prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate, • on the Kaiser Permanente Hawaii Drug Formulary and used in accordance with formulary criteria, guidelines, or restrictions, • the drug is one for which a prescription is required by law, • obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc., or pharmacies we designate, and • drug does not require administration by nor observation by medical personnel.	
	Insulin and certain diabetes supplies	$15 per prescription
	Contraceptive drugs and devices are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section	
	Exclusions: • Drugs related to obstetrical (maternity) care. • Drugs for which a prescription is not required by law (e.g. over-the-counter drugs) including condoms, contraceptive foams and creams or other non-prescription substances used individually or in conjunction with any other prescribed drug or device. • Drugs and their associated dosage strengths and forms in the same therapeutic category as a non-prescription drug that have the same indication as the non-prescription drug. • Drugs obtained from a non-Kaiser Permanente pharmacy. • Non-prescription vitamins. • Drugs when used primarily for cosmetic purposes. • Medical supplies such as dressings and antiseptics. • Reusable devices such as glucose monitors and lancet cartridges. • Non-formulary drugs or diabetes supplies, unless a non-formulary drug/diabetes supply has been specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate. • Brand-name drugs requested by a Member when there is a generic equivalent. • Prescribed drugs/diabetes supplies that are necessary for or associated with excluded or non-covered services. • Drugs related to sexual dysfunction. • Drugs to shorten the duration of the common cold. • Drugs related to enhancing athletic performance (such as weight training and body building). • Any packaging other than the dispensing pharmacy's standard packaging. • Immunizations, including travel immunizations. • Contraceptive drugs and devices (to prevent unwanted pregnancies). • Abortion drugs (such as RU-486). • Replacement of lost, stolen or damaged drugs.	

Questions and answers about the drug benefit for the Platinum Plan

1. How does the drug benefit work?

When you visit a Kaiser Permanente physician, a licensed prescriber or a prescriber we designate, and they prescribe a drug for which a prescription is legally required, you can take it to any Kaiser Permanente pharmacy or pharmacy we designate.

- In most cases you will be charged only $15 for a prescription when it does not exceed a 30-consecutive-day supply of a prescribed drug (or an amount as determined by the formulary). Each refill of the same prescription will also be provided at the same charge.
- If you go to a non-Kaiser Permanente pharmacy, you will be responsible for 100% of charges.

2. Where are Kaiser Permanente pharmacies located?

Most Kaiser Permanente Clinics have a pharmacy on premises. Please consult the Member Handbook for the pharmacy nearest you and its hours of operation.

3. Can I get any drug prescribed by my Physician?

Our drug formulary is considered a closed formulary, which means that medications on the list are usually covered under the prescription drug rider. However drugs on our formulary may not be automatically covered under your prescription drug rider depending on which plan you've selected. Even though nonformulary drugs are generally not covered under your prescription drug rider, your Kaiser Permanente physician can sometimes request a nonformulary drug for you, specifically when formulary alternatives have failed or use of nonformulary drug is medically necessary, provided -- the drug is not excluded under the prescription drug rider.

Kaiser Permanente pharmacies may substitute a chemical or generic equivalent for a brand-name drug unless this is prohibited by your Kaiser Permanente physician. If you want a brand-name drug for which there is a generic equivalent, or if you request a non-formulary drug, you will be charged Member Rates for these selections, since they are not covered under your prescription drug rider. If your KP physician deems a higher priced drug to be medically necessary when a less expensive drug is available, you pay the usual drug copayment. If you request the higher priced drug and it has not been deemed medically necessary, you will be charged Member Rates.

4. Do I need to present any identification when I receive drugs?

Yes, always present your Kaiser Permanente membership ID card, which has your medical record number, to the pharmacist. If you do not have a medical record number, please call the Customer Service Center at 432-5955 on Oahu or 1-800-966-5955 on Neighbor Islands.

5. What if I need more than a month's supply of medication?

Your Kaiser Permanente membership contract entitles you to a maximum one-month's supply per prescription. However, as a convenience to you, our Kaiser Permanente Pharmacies will dispense up to a three-month's supply of certain prescriptions upon request (you will be responsible for three copayment amounts). Dispensing a three-month's supply is done in good faith, presuming you will remain a Kaiser Permanente member for the next three months. If you terminate your membership with Kaiser Permanente before the end of the three-month period, we will bill you the retail price for your remaining drugs. For example, if you end your membership after two months, we will bill you for the remaining one-month's supply. Refills are allowed when 75% of the current prescription supply is taken/administered according to prescriber's directions.

6. How do I receive prescriptions by mail?

Use one of our convenient refill options and request that the refills be mailed to your home:

- The fastest option is ordering online at members.kp.org. (Use the "Special Instruction Box" on the "Finalize Your Order" screen to indicate special requests such as a change in quantity.)
- Order via our automated phone system called PRESTO! by calling 432-7979 (Oahu) or 1-888-867-2118 (Neighbor Islands).
- Order using our mail-order envelope, available at any Kaiser Permanente pharmacy.

You may purchase a 90-consecutive-days-supply of maintenance medications for the price of a 60-consecutive-days-supply. Some restrictions apply. The mail-order program does not apply to the delivery of certain pharmaceuticals (i.e., controlled substances as determined by state and/or federal regulations, bulky items, medication affected by temperature, injectables, and other products and dosage forms as identified by the Pharmacy and Therapeutics Committee). Prescriptions will only be mailed to your home, and will not be mailed to addresses outside of the Kaiser Permanente Hawaii Service Area. Place your order when you are down to your last 2 weeks' supply. Allow one week to receive your medication.

	Benefits	You pay
Optical benefit 1 for Platinum Plan	**When prescription is filled at Kaiser Permanente Optical Department:**	
	Glasses	
	• Once every 24 months and one pair of new lenses after 12 months	No charge ✦
	• Eye examinations for glasses should be scheduled in advance (covered according to base plan)	Applicable office visit copay
	Or	
	Contact lenses (in lieu of glasses)	
	• If member chooses - one pair of contact lenses every 24 months *	$45 less than regular cost
	• Eye examinations for contact lenses and fitting services	Eye examinations for contact lenses are excluded, but the member will receive a $70 professional fee credit for required initial or refitting exam (to apply towards the contact lenses examination) if contact lenses are purchased at a Kaiser Permanente facility.
	Members may elect to order items not covered under this rider. The following items are available at additional charges: • Tints including photochromic, polarized or tinted plastic lenses • Special lens materials such as polycarbonate and high-index materials • Multi-focal styles such as progressive lenses • Contact lenses, not medically required • Frames over $40 • Sunglasses	

✦ Glasses are regular scratch resistant lenses (plastic single vision, flat top (28 mm), multi-focal or lenticular lenses having refractive values) placed in a frame costing $40 or less. For members who are 18 years of age and under, the lens material will be impact resistant polycarbonate.

* If a member chooses disposable contact lenses, member may purchase as many months supply as needed. However the member's covered benefit will be limited to $45 once every 24 months.

	Benefits	You pay
Alternative medicine benefit C for Platinum Plan - 12 visits / $15	**Chiropractic and acupuncture services** **Up to a combined maximum of 12 office visits per calendar year.** **This rider does not cover services which are performed or prescribed by a Kaiser Permanente physician or other Kaiser Permanente health care provider.** Services must be performed and received from Participating Chiropractors and Participating Acupuncturists of **American Specialty Health Networks (ASHN)**. Covered Services include: • **Chiropractic services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders which are authorized by ASHN and performed by a Participating Chiropractor. • **Acupuncture services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea or Pain Syndromes which are authorized by ASHN and performed by a Participating Acupuncturist. • **Adjunctive therapy** as set forth in a treatment plan approved by ASHN, may involve chiropractic modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation; acupuncture therapies such as acupressure, moxibustion, and cupping; and other therapies. • **X-rays** when performed or ordered by a Participating Chiropractor and authorized by ASHN.	$15 copayment per office visit
	Chiropractic appliances when prescribed by a Participating Chiropractor and authorized by ASHN.	Payable up to a maximum of $50 per calendar year

Exclusions:

- Services, lab tests, x-rays and other treatments related to obstetrical (maternity) care.
- Any Chiropractic Service or treatment not furnished by a Participating Chiropractor and not provided in the Participating Chiropractor's office.
- Any Acupuncture Service or treatment not furnished by a Participating Acupuncturist and not provided in the Participating Acupuncturist's office.
- Examination and/or treatment of conditions other than Neuromusculo-skeletal Disorders from Participating Chiropractors and Neuromusculo-skeletal Disorders, Nausea, or Pain Syndromes from Participating Acupuncturists.
- Services, lab tests, x-rays and other treatments not documented as medically necessary or as appropriate.
- Services, lab tests, x-rays and other treatments classified as experimental or investigational.
- Diagnostic scanning and advanced radiographic imaging, including Magnetic Resonance Imaging (MRI), CAT scans, and/or other types of diagnostic scanning or therapeutic radiology; thermography; bone scans, nuclear radiology, any diagnostic radiology other than plain film studies.
- Alternative medical Services not accepted by standard allopathic medical practices including, but not limited to, hypnotherapy, behavior training, sleep therapy, weight programs, massage therapy, lomi lomi, educational programs, naturopathy, podiatry, rest cure, aroma therapy, osteopathy, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing.
- Vitamins, minerals, nutritional supplements or other similar-type products.
- Nutritional supplements which are Native American, South American, European, or of any other origin.
- Nutritional supplements obtained by Members through an acupuncturist, health food store, grocery store or by any other means.
- Traditional Chinese herbal supplements.
- Prescriptive and non prescriptive drugs, injectables and medications.
- Transportation costs, such as ambulance charges.
- Hospitalization, manipulation under anesthesia, anesthesia or other related Services.
- Laboratory Services and tests.
- Services or treatment for pre-employment physicals or vocational rehabilitation.
- Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance.

Benefits	You pay
• Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances, except as defined elsewhere in this brochure; all durable medical equipment, except as defined elsewhere in this brochure. • Services provided by a chiropractor or acupuncturist outside the State of Hawaii. • All auxiliary aids and services, such as interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids. • Adjunctive therapy not associated with acupuncture or chiropractic services. • Services and/or treatment which are not documented as Medically Necessary Services. • Any Services or treatment not authorized by ASHN, except for an initial examination. • Any office visits beyond 12 per calendar year.	

What you need to know about your alternative medicine benefits for the Platinum Plan

1. **Do I need to see my Kaiser Permanente physician to obtain a referral for a Participating Chiropractor or Participating Acupuncturist?**
   No. These alternative medicine services do not require a Kaiser Permanente physician's approval.
2. **How do I choose a chiropractor or acupuncturist?**
   You may select any chiropractor or acupuncturist who participates with ASHN. You may obtain a list with their addresses and phone numbers by calling the Kaiser Permanente Customer Service Center at 432-5955 on Oahu, and 1-800-966-5955 on Neighbor Islands. You may also view the list by logging on to our website at www.kp.org.
3. **Will an X-ray be covered if it is ordered by my chiropractor and performed at a Kaiser Permanente location?**
   Only medically necessary X-rays authorized by ASHN are covered. The X-rays must be performed in either a Participating Chiropractor's office or an ASHN participating ancillary provider's office in order to be covered.
4. **How do I obtain chiropractic or acupuncture services in Hawaii?**
   Simply select a Participating Chiropractor or Participating Acupuncturist and call to set-up an appointment. At your appointment, present your Kaiser Foundation Health Plan membership information card and pay your designated copayment.