

Kaiser Foundation Health Plan of Hawaii

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# IMPORTANT DETAILS AND NOTICES

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Kaiser Permanente for Individuals and Families

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## PRIVACY INFORMATION

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws.

We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes, such as quality assessment and improvement, customer service, and compliance programs. If you are enrolled in Kaiser Permanente through your employer or

employee organization, we may be allowed under the law to disclose certain PHI to them, such as information regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes we contract with others (business associates) to perform services for us and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please consult our *Notice of Privacy Practices*, which is available on our website, **kp.org**, and in our medical offices. You can also request a copy by calling our Customer Service Center.

If you have questions or concerns about our privacy practices, please contact our Customer Service Center at **808-432-5955** (Oahu) or **1-800-966-5955** (Neighbor Islands).

# KAISER PERMANENTE PROVIDERS – ISLAND OF OAHU

## BEHAVIORAL HEALTH SERVICES

Ala Moana Building  
1441 Kapiolani Blvd., Suite 1600  
Honolulu, HI 96814  
**808-432-7600**

### Clinic hours

Monday–Friday ..... 8:00 a.m.–5 p.m.  
Closed weekends and holidays

## HAWAII KAI CLINIC

6700 Kalanianaʻole Highway, Suite 111  
Honolulu, HI 96825  
**808-432-3700**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.  
Saturday ..... 8 a.m.–noon  
Closed Sunday and holidays

## HONOLULU CLINIC

1010 Pensacola St.  
Honolulu, HI 96814  
**808-432-2000**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.  
Saturday ..... 8 a.m.–noon  
Closed Sunday and holidays

### Urgent care hours

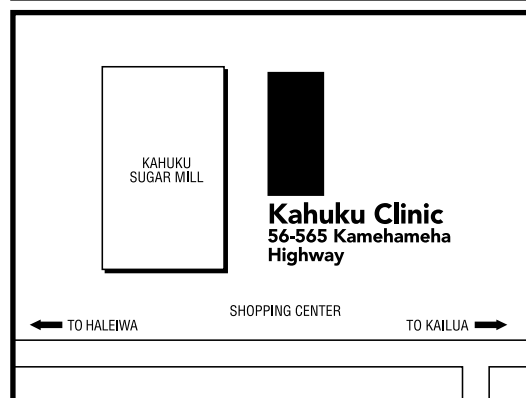
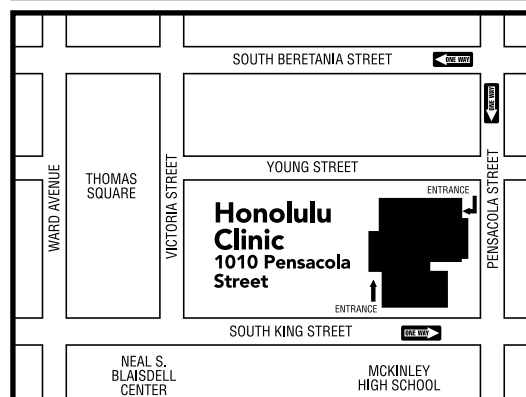
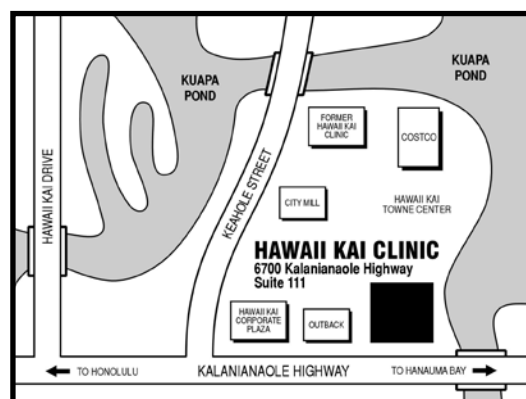
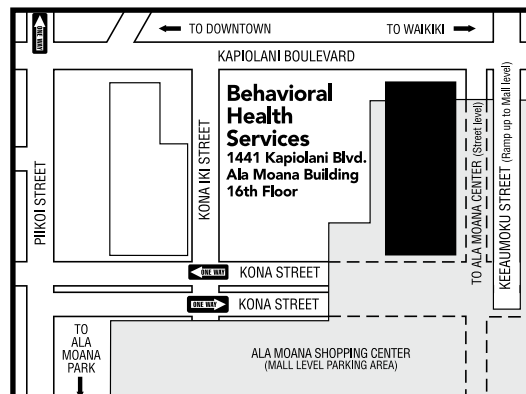
Monday–Saturday ..... 8 a.m.–6 p.m.  
Closed Sunday and holidays

## KAHUKU CLINIC

56-565 Kamehameha Highway  
Kahuku, HI 96731  
**808-432-3900**

### Clinic hours

Monday–Friday ..... 8:30 a.m.–noon, 1–5 p.m.  
Saturday ..... 8:30 a.m.–noon  
Closed Sunday and holidays



# KAISER PERMANENTE PROVIDERS – ISLAND OF OAHU

## KAILUA CLINIC

201 Hamakua Drive, Building B

Kailua, HI 96734

**808-432-3400**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.

Saturday ..... 8 a.m.–noon

Closed Sunday and holidays

## KAPOLEI CLINIC

599 Farrington Highway

Kapolei, HI 96707

**808-432-3100**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.

Closed weekends and holidays

## KOOLAU CLINIC

45-602 Kamehameha Highway

Kaneohe, HI 96744

**808-432-3800**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.

Saturday ..... 8 a.m.–noon

Closed Sunday and holidays

## MAPUNAPUNA CLINIC

2828 Paa St.

Honolulu, HI 96819

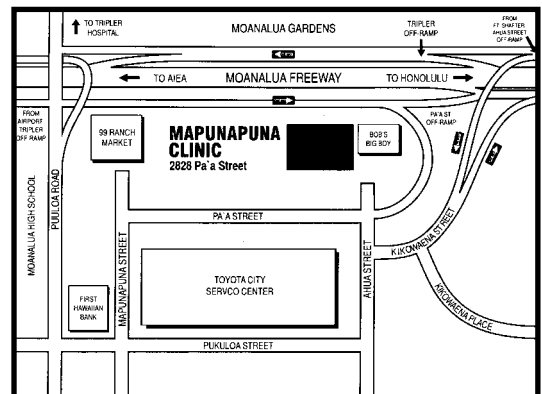
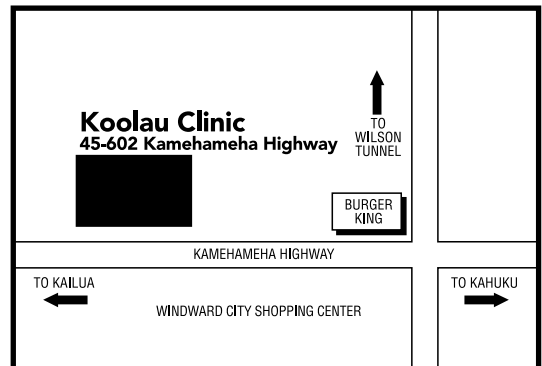
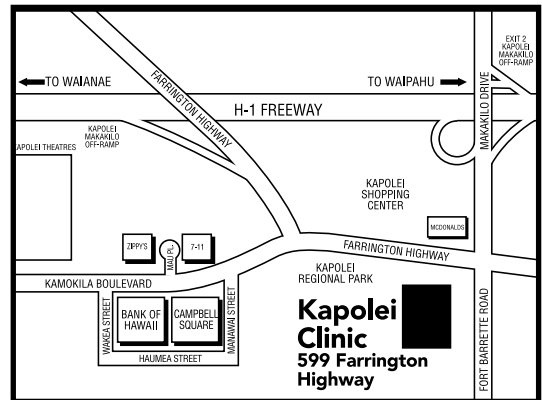
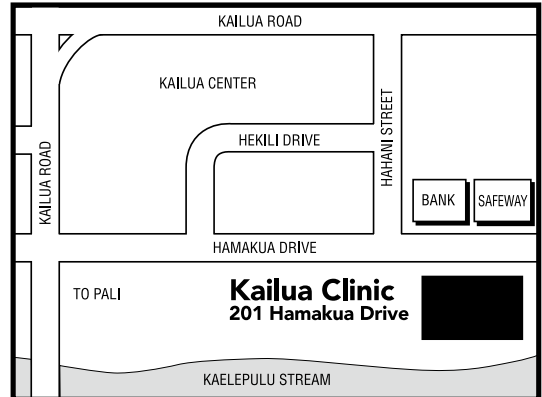
**808-432-5770**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.

Saturday ..... 8 a.m.–noon

Closed Sunday and holidays



# KAISER PERMANENTE PROVIDERS – ISLAND OF OAHU

## MOANALUA MEDICAL CENTER AND CLINIC

3288 Moanalua Road  
Honolulu, HI 96819  
**808-432-0000**

### Clinic hours

Monday–Friday ..... 8:30 a.m.–5 p.m.  
Saturday ..... Please call for hours.  
Closed Sunday and holidays

## NANAIKEOLA CLINIC

87-2116 Farrington Highway  
Waianae, HI 96792  
**808-432-3100**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.  
Saturday ..... 8 a.m.–noon  
Closed Sunday and holidays

## WAIPIO CLINIC

94-1480 Moaniani St.  
Waipahu, HI 96797  
**808-432-3100**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.  
Saturday ..... 8 a.m.–noon  
Closed Sunday and holidays

## Island of Oahu

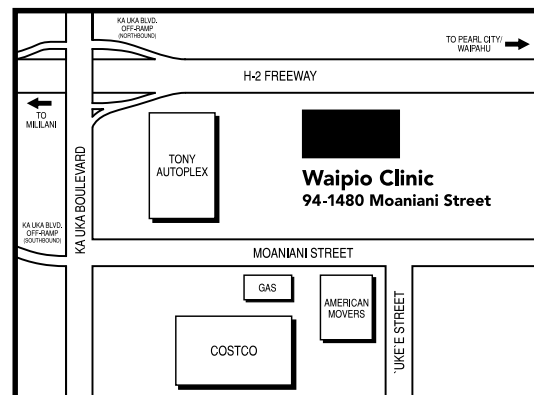
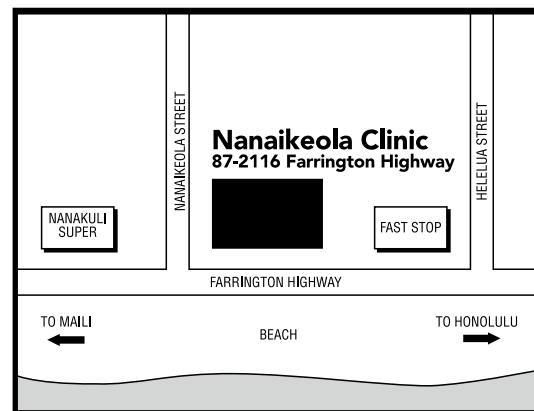
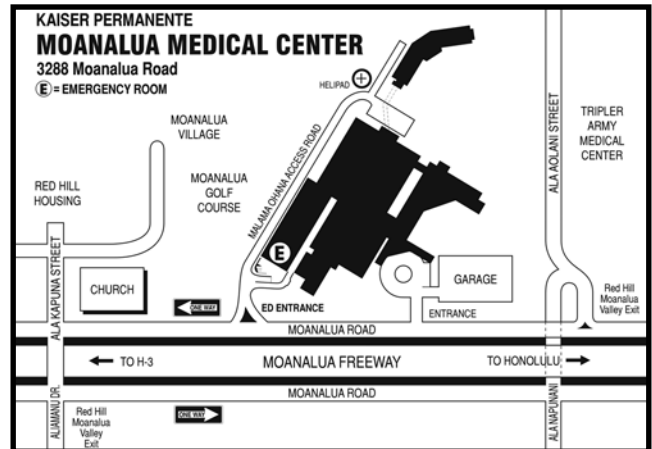
### Emergency and urgent care

#### Moanalua Medical Center

3288 Moanalua Road, Honolulu, HI 96819  
**24 HOURS EVERY DAY, INCLUDING HOLIDAYS**  
**808-432-0000**

#### After-hours care at Moanalua Medical Center

Monday–Friday ..... 5–10 p.m.  
Saturday ..... 1–10 p.m.  
Sunday and holidays ..... 8 a.m.–10 p.m.  
Please call for an appointment: **808-432-7700**



# KAISER PERMANENTE PROVIDERS – ISLAND OF MAUI

## KIHEI CLINIC

1279 South Kihei Road, Suite 120

Kihei, HI 96753

**808-891-6800**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.

Closed weekends and holidays

## LAHAINA CLINIC

910 Wainee St.

Lahaina, HI 96761

**808-662-6900**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.

Saturday ..... 8 a.m.–noon

Closed Sunday and holidays

## MAUI LANI CLINIC

55 Maui Lani Parkway

Wailuku, HI 96793

**808-243-6050**

### Clinic hours

Monday–Friday ..... 8 a.m.–8 p.m.

Weekends and holidays ..... 8 a.m.–5 p.m.

Closed Christmas Day and New Year's Day

## WAILUKU CLINIC

80 Mahalani St.

Wailuku, HI 96793

**808-243-6000**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.

Closed weekends and holidays

## Island of Maui

### Emergency and urgent care

### Maui Memorial Medical Center

221 Mahalani St., Wailuku, HI 96793

**24 HOURS EVERY DAY, INCLUDING HOLIDAYS**

**808-242-2343**

### After-hours care at Maui Lani Clinic

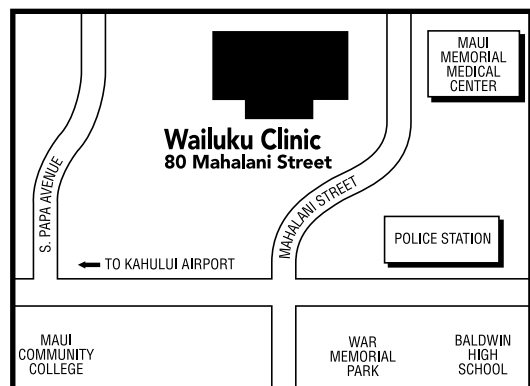
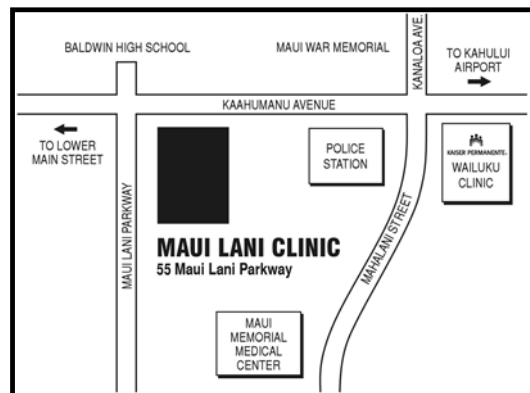
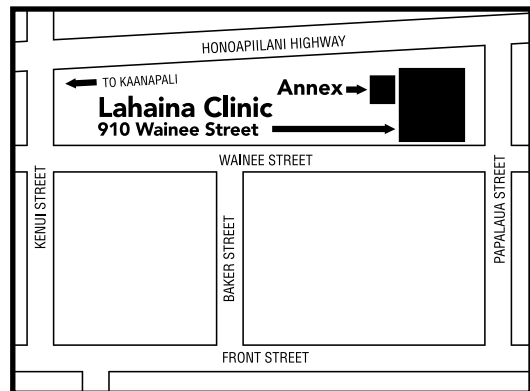
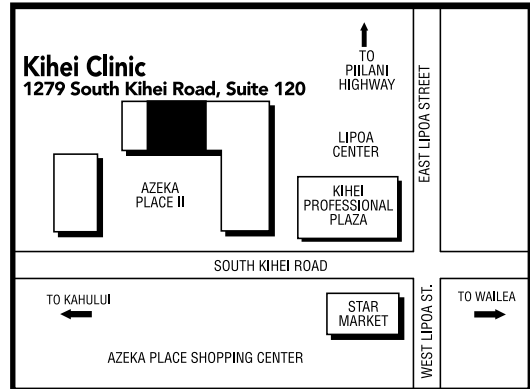
Monday–Friday ..... 5–8 p.m.

Saturday ..... noon–5 p.m.

Sunday and most holidays ..... 8 a.m.–5 p.m.

Closed Christmas Day and New Year's Day

Please call for an appointment: **808-243-6050**



# KAISER PERMANENTE PROVIDERS – ISLAND OF HAWAII

## HILO CLINIC

1292 Waianuenue Ave.

Hilo, HI 96720

**808- 934-4000**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.

Saturday ..... 8 a.m.–noon

Closed Sunday and holidays

## KONA CLINIC

Hualalai Medical Center

75-184 Hualalai Road

Kailua-Kona, HI 96740

**808-334-4400**

### Clinic hours

Monday–Friday ..... 8 a.m.–5 p.m.

Saturday ..... 8 a.m.–noon

Closed Sunday and holidays

## SOUTH KONA CLINIC

81-6350 Mamalahoa Highway, Unit #2

Kealahou, HI 96750

**808-747-8800**

### Clinic hours

Monday–Friday ... 8:30 a.m.–12:30 p.m. and 1:30–5 p.m.

## WAIMEA CLINIC

Parker Ranch Shopping Center

67-1185A Mamalahoa Highway

Kamuela, HI 96743

**808-881-4500**

### Clinic hours

Monday–Friday ..... 8 a.m.–12:30 p.m. and 1:30–5 p.m.

Saturday ..... 8 a.m.–noon

Closed Sunday and holidays

## Island of Hawaii

**Emergency and urgent care**

### Hilo Medical Center

1190 Waianuenue Ave., Hilo, HI 96720

**808-974-4700**

### Kona Community Hospital

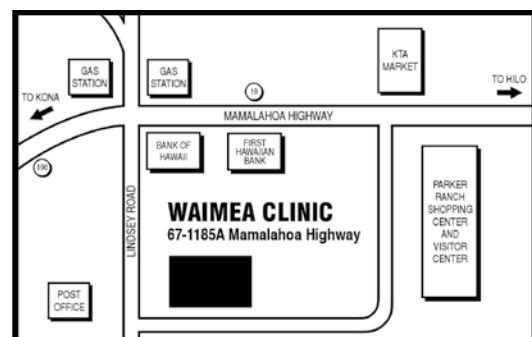
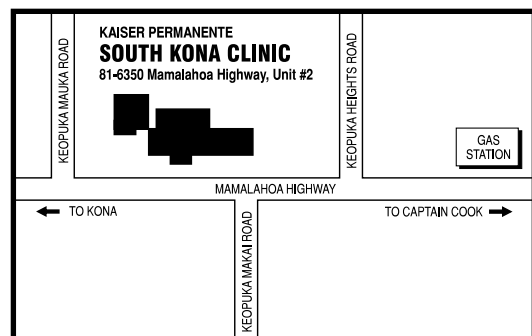
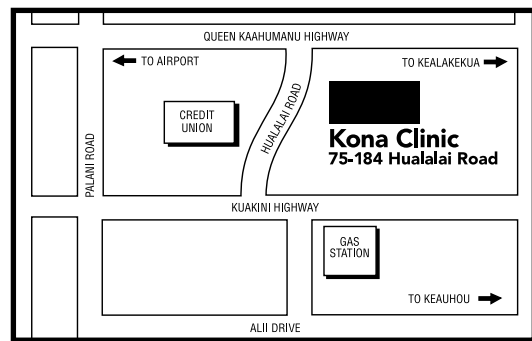
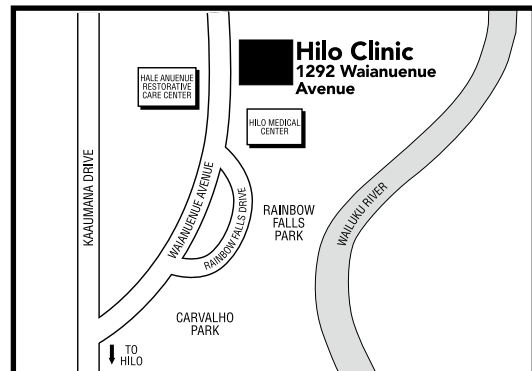
79-1019 Haukapila St., Kealahou, HI 96750

**808-322-4413**

### North Hawaii Community Hospital

67-1125 Mamalahoa Highway, Kamuela, HI 96743

**808-881-4730**



# KAISER PERMANENTE PROVIDERS – ISLAND OF KAUAI

On the island of Kauai, we have contracted for in-network services with select independent physicians and other providers, listed below by specialty.

**Information in this brochure is current as of September 2011 and may be subject to change without notice.**

A provider's listing in the directory does not guarantee that the provider is still in the network or accepting new members. If you would like more current information on a practitioner's license, call either the Department of Commerce and Consumer Affairs Consumer Resource Center at **808-587-3295** or the Kaiser Permanente Customer Service Center toll free at **1-800-966-5955**).

## Primary care physicians

### Family Medicine

Sharon Ayabe, MD<sup>1</sup>  
Kapaa Family Medicine  
**808-822-4333**

Mary L. Cameron, NP-C  
Hale Lea Medicine  
**808-828-2885**

Paul Esaki, MD<sup>1</sup>  
Kapaa Family Medicine  
**808-822-4333**

Charlotte Hunter, MD  
North Shore Medical Center  
**808-828-1418**

Richard B. Lewan, MD  
West Kauai Clinic at Kalaheo  
**808-332-8523**

Melinda Menezes, MD<sup>1</sup>  
North Shore Medical Center  
**808-828-1418**

R. Craig Netzer, MD<sup>1</sup>  
Lihue  
**808-246-2002**

Michael J. O'Neill, MD  
West Kauai Clinic at Waimea  
**808-335-8311**

Steven M. Rogoff, MD  
Hale Lea Medicine  
**808-828-2885**

James Winkler, PA-C  
Hale Lea Medicine  
**808-828-2885**

Ellen Wright, NP<sup>2</sup>  
Aloha Medical Center  
**808-246-3800**

David E. Zimmerman, MD  
West Kauai Clinic at Kalaheo  
**808-332-8523**

### General Practice

Edward Lanson, MD<sup>2</sup>  
Aloha Medical Center  
4484 Pahee St.  
**808-246-3800**

### Internal Medicine

Michael Braun, MD<sup>1</sup>  
Lihue  
**808-246-2002**

Thomas Capelli, MD  
North Shore Medical Center  
**808-828-1418**

Constante J. "Paul" Flora, MD<sup>2</sup>  
Aloha Medical Center  
**808-246-3800**

C. Mitchell Jenkins, MD  
West Kauai Clinic at Eleele  
**808-335-0579**

Sally Jo Moore, RN, PA-C  
North Shore Medical Center  
**808-828-1418**

R. Craig Netzer, MD<sup>1</sup>  
4473 Pahee St., #O  
**808-246-2002**

Mary Linda Paul, MD  
West Kauai Clinic at Waimea  
808-338-8311

### Pediatrics

Terrance Carolan, MD  
Kauai Pediatrics  
**808-245-8566**

James F. Raelson, MD  
West Kauai Clinic at Waimea  
**808-338-8311**

Jami A. Knox, MD  
West Kauai Clinic at Eleele  
**808-335-0579**

Jami A. Knox, MD  
West Kauai Clinic at Kalaheo  
**808-332-8523**

<sup>1</sup>Not accepting new patients

<sup>2</sup>Ages 13 and up



# KAISER PERMANENTE PROVIDERS – ISLAND OF KAUAI

## Self-referral services

### Health Management

Rhonda Pabo, RN, FNP  
Kauai Medical Clinic  
**808-246-1380**

Mary Roush, RN, CDE  
Kauai Medical Clinic  
**808-246-1380**

Don Traller, PA-C  
Kauai Medical Clinic  
**808-246-1380**

### Obstetrics/Gynecology

Virginia Beck, NP  
West Kauai Clinic at Eleele  
**808-335-0579**

Surachat Chatkupt, MD  
West Kauai Clinic at Waimea  
**808-338-8311**

Graham Chelius, MD  
Samuel Mahelona Memorial  
Hospital  
**808-338-8311**

Graham Chelius, MD  
West Kauai Clinic at Waimea  
**808-338-8311**

John R. Wichert, MD  
West Kauai Clinic at Eleele  
**808-335-0579**

John R. Wichert, MD  
North Shore Medical Center  
**808-828-1418**

### Optometry

Glenn Belisle, OD  
Kauai Optometric Center  
**808-822-3733**

Timothy B. Crane, MD  
Crane Eye Care  
**808-246-0110**

Layne Hashimoto, OD  
Eye Care Center of Kauai  
**808-246-0051**

Timothy Lee, MD  
Eye Care Center of Kauai  
**808-246-0051**

Jere H. L. Loo, OD  
Kukui Grove Shopping Center  
**808-245-8564**

Chet A. Myers, OD  
Lihue  
**808-245-2772**

Michael K. H. Oride, OD  
Lihue  
**808-245-8765**

Gardner C. Quarton Jr., MD  
Kapaa Family Eye Care  
**808-821-2707**

Stanley J. Schiller, OD  
Lihue  
**808-246-8855**

Jean Shein, MD  
Eye Care Center of Kauai  
**808-246-0051**

Larry K. Sherrer, MD  
Pacific Eye Center  
**808-245-5377**

### Mental Health Counseling

Michael E. Foley, MSW  
Lihue  
**808-651-8269**

Karin Stoll, MSW, DCSW  
Lihue  
**808-632-2010**

### Psychiatry

Gerald J. McKenna, MD  
Lihue

**808-246-0663**  
Tiffany Niide, MD

Kapaa  
**808-346-2964**

Jon W. Nakamura, MD  
Lihue  
**808-246-6253**

Stephanie Skow, MD  
Lihue  
**808-634-2376**

### Psychology

Fahy Bailey, PhD  
Kapaa  
**808-822-2447**

Dianne Gerard, PhD  
Lihue  
**808-246-4501**

Robert A. Horne, PhD  
Lihue  
**808-245-6116**

Patrick F. McGivern, PhD  
Lihue  
**808-245-5659**

### Substance Abuse

Ke Ala Pono  
Lihue  
**808-245-5659**

### Women's Health Services

Virginia Beck, NP  
West Kauai Clinic at Eleele  
**808-335-0579**

Surachat Chatkupt, MD  
West Kauai Clinic at Waimea  
**808-338-8311**

Graham Chelius, MD  
Samuel Mahelona Memorial  
Hospital  
**808-338-8311**

Graham Chelius, MD  
West Kauai Clinic at Waimea  
**808-338-8311**

Charlotte Hunter, MD  
North Shore Medical Center  
**808-828-1418**

Melinda Menezes, MD  
North Shore Medical Center  
**808-828-1418**

John R. Wichert, MD  
West Kauai Clinic at Eleele  
**808-335-0579**

John R. Wichert, MD  
North Shore Medical Center  
**808-828-1418**

Ellen Wright, NP  
Aloha Medical Center  
**808-246-3800**

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# KAISER PERMANENTE PROVIDERS – ISLAND OF KAUAI *(continued)*

## Specialists<sup>1</sup>

### Audiology

Shannon Ching  
Hawaii Professional Audiology  
**808-652-7345**

### Cardiology

John T. Funai, MD  
Kauai Medical Clinic  
**808-245-1548**

David L. Sable, MD  
Kauai Medical Clinic  
**808-245-1548**

Andrew So, DO  
Kauai Medical Clinic  
**808-245-1548**

### Dermatology

Thomas Potter, MD  
Kauai Dermatology, LLC  
**808-246-6904**

### Diabetes Educator

Mary Roush, RN, CDE  
Kauai Medical Clinic  
**808-246-1380**

### Diagnostic Imaging Services

West Kauai Medical Center  
Waimea  
**808-338-9431**

Samuel Mahelona Memorial  
Hospital—limited X-ray services  
**808-822-4961**

Wilcox Memorial Hospital  
Lihue  
**808-245-1033**

### Dialysis

Liberty Dialysis  
Lihue  
**808-245-3770**

Liberty Dialysis  
Waimea  
**808-338-1101**

### Durable Medical Equipment

Apria Healthcare, Inc.  
Kaiser Permanente DME:  
**808-432-7802**  
Urgent requests:  
**808-485-0178**

### Ear, Nose, & Throat

H. Roger Netzer, MD  
Kauai Medical Clinic  
**808-245-1529**

Jay Murphy, MD  
Kauai Medical Clinic  
**808-245-1529**

### General Surgery

Elisabeth Biuk-Aghai  
West Kauai Clinic at Waimea  
**808-338-8311**

Emilia Dauway-Williams, MD  
North Shore Medical Center  
**808-828-1418**

Emilia Dauway-Williams, MD  
Kuhio Medical Center  
**808-245-8874**

Emilia Dauway-Williams, MD  
West Kauai Clinic at Waimea  
**808-338-8311**

### Home Care Services

St. Francis Home Care Services  
Lihue  
**808-245-6430**

### Hospice Services

Kauai Hospice  
Lihue  
**808-245-7277**

### Infectious Disease

James Yoon, DO  
Kauai Medical Clinic  
**808-245-1540**

### Laboratory Services

Clinical Laboratory Services of  
Hawaii—Dynasty Court  
Lihue  
**808-245-7775**

Clinical Laboratory Services of  
Hawaii—Waimea  
**808-338-9432**

Clinical Laboratory Services of  
Hawaii—Wilcox Hospital  
Lihue  
**808-245-1074**

Diagnostic Laboratory Services—  
Aloha Medical Center  
**808-245-9608**

Diagnostic Laboratory Services—  
Kalaheo  
**808-332-0283**

Diagnostic Laboratory Services—  
Kuhio Medical Center  
**808-245-7130**

### Nephrology

Niraj Desai, MD  
Kidney Care of Hawaii  
**808-632-0200**

### Neurology

Surendra Rao, MD  
Kauai Medical Clinic  
**808-246-1687**

### Occupational Therapy

Action Physical Therapy  
**808-246-0144**  
West Kauai Medical Center  
Waimea  
**808-338-9431**

Samuel Mahelona Memorial  
Hospital  
Kapaa  
**808-822-4961**

### Ophthalmology

Timothy B. Crane, MD  
Crane Eye Care  
**808-246-0110**  
Timothy Lee, MD  
Eye Care Center of Kauai  
**808-246-0051**

<sup>1</sup>Not accepting new patients

# KAISER PERMANENTE PROVIDERS – ISLAND OF KAUAI

## Specialists<sup>1</sup>

Gardner C. Quarton Jr., MD  
Kapaa Family Eye Care  
**808-821-2707**

Jean Shein, MD  
Eye Care Center of Kauai  
**808-246-0051**

Larry K. Sherrer, MD  
Pacific Eye Center  
**808-245-5377**

### Orthopedics

Richard Goding, MD  
West Kauai Clinic at Waimea  
**808-338-8311**

Richard Goding, MD  
North Shore Medical Center  
**808-828-1418**

Richard Goding, MD  
Kuhio Medical Center  
**808-245-8874**

Richard Goding, MD  
Hale Lea Medicine  
**808-828-2885**

Hayato Mori, MD  
Lihue  
**808-639-1100**

### Physiatry

Heather Hopkins, MD  
Kauai Medical Clinic  
**808-245-1524**

### Physical Therapy

Action Physical Therapy  
Lihue  
**808-246-0144**

Steve Backinoff, PT  
Kilauea  
**808-828-0416**

Cheryl Claypool, PT  
Aloha Sports Medicine & Physical  
Therapy  
**808-828-1128**

West Kauai Medical Center  
Waimea  
**808-338-9431**

Samuel Mahelona Memorial  
Hospital  
Kapaa  
**808-822-4961**

Jonathan R. Rider, PT  
Hanalei  
**808-826-7433**

Todd Strong, PT  
Hale Lea Medicine  
**808-828-0030**

### Podiatry

Tyler Chihara, DPM  
Kauai Medical Clinic  
**808-245-1524**

### Urology

William Bodenstab, MD  
Kauai Medical Clinic  
**808-245-1505**

Agustinus Rushanaedy, MD  
Kauai Medical Clinic  
**808-245-1505**

### Pharmacies

Foodland Pharmacy—Waipouli  
**808-821-6979**

Foodland Pharmacy—Princeville  
**808-826-4228**

Lifeway Pharmacy—Lihue  
**808-245-2471**

Lifeway Pharmacy—Waimea  
**808-338-0600**

Lihue Pharmacy  
**808-246-9100**

Longs Drugs—Eleele  
**808-335-0700**

Longs Drugs—Kapaa  
**808-822-4918**

Longs Drugs—Lihue Kukui Grove  
**808-245-8871**

Menehune Pharmacy  
Waimea  
**808-338-0200**

Northshore Pharmacy  
Kilauea  
**808-828-1844**

Papalina Pharmacy  
Kalaheo  
**808-332-9130**

Southshore Pharmacy  
Koloa  
**808-742-7511**

WalMart Pharmacy  
Lihue  
**808-246-1822**

Westside Pharmacy  
Hanapepe  
**808-335-5342**

### Hospitals

West Kauai Medical Center  
Waimea  
**808-338-9431**

Samuel Mahelona Memorial  
Hospital  
Kapaa  
**808-822-4961**

Wilcox Memorial Hospital  
Lihue  
**808-245-1100**

<sup>1</sup>Not accepting new patients

## Kaiser Permanente 20/Rx Plan 2012 Benefits summary

**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 Non-Group Medical and Hospital Service Agreement, benefit schedule, and Riders (collectively known as “Service Agreement”). The Service Agreement is the legally 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
<b>Outpatient services</b>	<b>Primary care and specialty care office visits</b> (office visits are limited to one or more of the following services: exam, history, medical decision making)  <i>Choice of primary care providers and access to specialty care:</i> <ul style="list-style-type: none"> <li>Member may choose any primary care physician available to accept Member.</li> <li>Parents may choose a pediatrician as the primary care physician for their child.</li> <li>Members do not need a referral or prior authorization for certain specialty care, such as Gynecological care.</li> <li>The physician may have to get prior authorization for certain services.</li> </ul> <ul style="list-style-type: none"> <li>Eye examinations for eyeglasses *</li> <li>Ear examinations to determine the need for hearing correction</li> </ul>	\$20 per visit
	<b>Outpatient surgery and procedures</b>	\$20 per visit (in doctor's office)  \$75 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<b>Preventive care services</b> (which protect against disease, promote health, and/or detect disease in its earliest stages before noticeable symptoms develop)  <i>A list of preventive care services provided at no charge is available through the Customer Service Center. This list is subject to change at any time. If you receive any other covered services during a preventive care visit, you will pay the applicable charges for those services.</i>	No charge (non-preventive care services according to member's regular plan benefits)
	<b>Preventive care office visits for:</b> <ul style="list-style-type: none"> <li>Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, and 5 years)</li> <li>One preventive care office visit per calendar year for members over 5 years of age</li> <li>One gynecological office visit per calendar year for female members</li> </ul>	No charge
	<b>Routine immunizations</b>	No charge
	<b>Unexpected mass immunizations</b>	50% of applicable charges
	<b>Short-term physical, occupational and speech therapy **</b> (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply)	\$20 per visit
	<b>Dialysis</b> <ul style="list-style-type: none"> <li>Kaiser Permanente physician and facility services for dialysis</li> <li>Equipment, training and medical supplies for home dialysis</li> </ul>	10% of applicable charges  No charge

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section



Section	Benefits	You pay
<b>Obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services</b>	<b>Obstetrical (maternity) care</b> <ul style="list-style-type: none"> <li>All maternity care is <u>not covered</u> (such as prenatal visits, delivery/hospital stay, post-partum visits, related labs, diagnostic imaging etc.)</li> </ul>	All charges (maternity care is not covered)
	<b>Inpatient stay and inpatient care for newborn</b> 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)
	<b>Interrupted pregnancy</b> <ul style="list-style-type: none"> <li>Medically indicated abortions</li> </ul>	\$20 per visit (in doctor's office) \$75 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<ul style="list-style-type: none"> <li>Elective abortions (including abortion drugs such as RU-486) limited to two per member per lifetime</li> </ul>	\$20 per visit (in doctor's office) \$75 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<b>Family planning office visits</b>	\$20 per visit
	<b>FDA approved contraceptive drugs and devices **</b> (to prevent unwanted pregnancies)	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply) ▼
	<b>Involuntary infertility office visits</b>	\$20 per visit
	<b>Artificial insemination *</b>	\$20 per visit
	<b>In vitro fertilization *</b> <ul style="list-style-type: none"> <li>Limited to one-time only benefit at Kaiser Permanente</li> <li>Limited to female members using spouse's sperm</li> </ul>	20% of applicable charges
	<b>Home health care</b> , nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	No charge
	<b>Hospice care.</b> 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: <ul style="list-style-type: none"> <li>Nursing care (excluding private duty nursing)</li> <li>Medical social services</li> <li>Home health aide services</li> <li>Medical supplies</li> <li>Kaiser Permanente physician services</li> <li>Counseling and coordination of bereavement services</li> <li>Services of volunteers</li> <li>Physical therapy, occupational therapy, or speech language pathology</li> </ul>	No charge

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Skilled nursing care</b>	<p>Up to <b>60 days of prescribed skilled nursing care services in an approved facility</b> (such as a hospital or skilled nursing facility) <b>per benefit period</b>. Covered services include nursing care, room and board, medical social services, medical supplies, and durable medical equipment ordinarily provided by a skilled nursing facility.</p> <p>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.</p> <p><b>Exclusions:</b> Personal comfort items, such as telephone, television and take-home medical supplies.</p>	No charge
<b>Emergency services</b> ▲ (covered for initial emergency treatment only)	<p>At a facility <u>within</u> the Hawaii service area for covered emergency services</p> <p>At a facility <u>outside</u> the Hawaii service area for covered emergency services</p> <p>Note: Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility.</p> <p>▲ <i>Emergency Services are those medically necessary services available through the emergency department to medically screen, examine and Stabilize the patient for Emergency Medical Conditions. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity that meet the prudent layperson standard and the absence of immediate medical attention will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or place the health of the individual in serious jeopardy. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.</i></p>	<p>\$75 copay per visit</p> <p>\$75 copay per visit</p>
<b>Urgent care services</b>	<p>At a Kaiser (or Kaiser-designated) urgent care center within the Hawaii service area for covered urgent care services</p> <p>At a non-Kaiser Permanente facility outside the Hawaii service area for covered urgent care services</p> <p>(Coverage for initial urgent care treatment only) ❖</p> <p>❖ <i>"Urgent Care Services" means medically necessary services for a condition that requires prompt medical attention but is not an Emergency Medical Condition. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.</i></p>	<p>\$20 per visit</p> <p>20% of applicable charges</p>
<b>Ambulance services</b>	<p>Ambulance Services are those services in which:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Is for the purpose of transporting the member to receive medically necessary acute care.</li> </ul> <p>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.</p>	20% of applicable charges
<b>Blood</b>	<p>Regardless of replacement, units and processing of units of <b>whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin</b></p> <p>Collection, processing, and storage of <b>autologous blood</b> when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used</p>	<p>No charge</p> <p>No charge</p>

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Mental health services *</b> for serious mental illness	<p>“Serious mental illness” includes schizophrenia, schizo-affective disorder, bipolar types I and II, delusional disorder, major depression, obsessive-compulsive disorder, and dissociative disorder.</p> <p>Outpatient office visits</p> <p>Hospital inpatient care</p>	<p>\$20 per visit</p> <p>\$150 per day</p>
<b>Mental health services *</b> for non-serious mental illness	<p><b>Up to 24 outpatient office visits per calendar year</b></p> <ul style="list-style-type: none"> <li>Psychological testing * as part of diagnostic evaluation, when ordered by a Kaiser Permanente physician or psychologist</li> </ul> <p><b>Additional outpatient office visits</b> 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</p> <p><b>Up to 30 days of hospital care per calendar year</b> 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.)</p> <ul style="list-style-type: none"> <li>Hospital care Services of Kaiser Permanente physicians, mental health professionals and other health care professionals, or Kaiser Permanente physician's visits in specialized facility</li> <li>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</li> </ul>	<p>20% of applicable charges</p> <p>20% of applicable charges</p> <p>20% of applicable charges</p> <p>20% of applicable charges</p> <p>20% of applicable charges</p>
<b>Chemical dependency services **</b>	<p>Outpatient office visits</p> <p>Hospital inpatient care</p> <p>Up to 60 days per calendar year of residential chemical dependency services *</p>	<p>\$20 per visit</p> <p>\$150 per day</p> <p>20% of applicable charges</p>
<b>Internal prosthetics, devices, and aids</b>	<p><b>Implanted internal prosthetics</b> (such as pacemakers and hip joints), <b>and internally implanted devices and aids</b> (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</p> <p>Fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss</p> <p><b>Internal prosthetics</b> are those which meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>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,</li> <li>Are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA),</li> <li>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</li> <li>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.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>All implanted internal prosthetics and devices and internally implanted aids related to an excluded or non-covered service/benefit</li> <li>Prosthetics, devices, and aids related to sexual dysfunction</li> </ul> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>	<p>No charge</p> <p>No charge</p>

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section



Section	Benefits	You pay
<b>Diabetes and home phototherapy equipment</b>	<b>Diabetes equipment</b> (limited to blood glucose monitors 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	50% of applicable charges
	<b>Home phototherapy equipment for newborns</b> 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	No charge
	<p><b>Diabetes and home phototherapy equipment</b> is that equipment and supplies necessary to operate the equipment which:</p> <ul style="list-style-type: none"> <li>• Is intended for repeated use,</li> <li>• Is primarily and customarily used to serve a medical purpose,</li> <li>• Is appropriate for use in the home,</li> <li>• Is generally not useful to a person in the absence of illness or injury,</li> <li>• 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,</li> <li>• 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</li> <li>• Is on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Comfort and convenience equipment, and devices not medical in nature.</li> <li>• Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages.</li> <li>• Repair, adjustment or replacement due to misuse or loss.</li> <li>• Experimental or research equipment.</li> </ul> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>• If rented or loaned from Health Plan, the Member must return any diabetes or home phototherapy 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.</li> <li>• Coverage is limited to the standard item of diabetes or home phototherapy equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.</li> </ul>	

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Supplemental charges maximum</b>	<p><b>Your out-of-pocket expenses for covered Basic Health Services are capped each year by a supplemental charges maximum.</b></p> <p><b><i>YOU MUST RETAIN YOUR RECEIPTS</i></b> for these supplemental charges and when that maximum amount has been <b>PAID</b>, 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 <b>PAID</b>, <b>you will be given a card</b> 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 <b>show this card</b> 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. <b>All payments are credited toward the calendar year in which the medical services were received.</b></p> <p>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.</p> <p>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.</p> <p><b>Supplemental charges for the following covered Basic Health Services</b> can be applied toward the supplemental charges maximum: 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, covered office visits for services listed in this Basic Health Services section, 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.</p> <p>These are not Basic Health Services and charges for these services/items are <b><i>not</i></b> applicable towards the supplemental charges maximum: all services for which coverage has been exhausted, 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.</p>	\$2,500 per member

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

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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 external prosthetic devices and braces portion of this exclusion may not apply if you have an External Prosthetic Devices and Braces Rider. The hearing aids portion of this exclusion may not apply if you have a Hearing Aid Rider. The eyeglasses and contact lens portion of this exclusion may not apply if you have an Optical 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, including treatment for complications resulting from cosmetic services. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery, incident to a covered mastectomy, or cosmetic service provided by a Physician in a Health Plan facility 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 blood glucose monitors 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 vision therapy, including orthoptics, visual training and **eye exercises**.
- **Eye surgery** solely for the purpose of correcting refractive defects of the eye, such as Radial keratotomy (RK), and Photo-refractive keratectomy (PRK).
- **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.
- 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.**

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## \*\* 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.
- Up to a 30-consecutive-day supply of **diabetes supplies** is provided (as described under the **prescribed drugs** section) if all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate.
- 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.
- Up to a 30-consecutive-day supply of **tobacco cessation drugs and products** is provided when all of the following criteria are met: 1) available on the Health Plan formulary's Tobacco Cessation list of approved drugs and products, including over-the-counter drugs and products, and in accordance with formulary criteria, guidelines, or restrictions, 2) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate, and 3) Member meets Health Plan-approved program-defined requirements for smoking cessation classes or counseling (tobacco cessation classes and counseling sessions are provided at no charge).
- **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 Kaiser Permanente 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.

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### 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.

Section	Benefits	You pay
<b>Drug benefit 20 for KP 20/Rx Plan</b>	<p><b>For each prescription, when the quantity does not exceed:</b></p> <ul style="list-style-type: none"> <li>a 30–consecutive-day supply of a prescribed drug, or</li> <li>an amount as determined by the formulary.</li> </ul> <p><b>Self-administered drugs</b> are covered only when all of the following criteria are met:</p> <ul style="list-style-type: none"> <li>prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate,</li> <li>on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions,</li> <li>the drug is one for which a prescription is required by law,</li> <li>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</li> <li>drug does not require administration by nor observation by medical personnel.</li> </ul> <p><b>Insulin</b></p> <p><b>Diabetes supplies and tobacco cessation drugs and products</b> are described in the prescribed drugs section</p> <p><b>Contraceptive drugs and devices</b> are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section</p> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>Drugs related to obstetrical (maternity) care.</li> <li>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. This exclusion does not apply to tobacco cessation drugs and products as described in the prescribed drugs section.</li> <li>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.</li> <li>Drugs obtained from a non-Kaiser Permanente pharmacy.</li> <li>Non-prescription vitamins.</li> <li>Drugs when used primarily for cosmetic purposes.</li> <li>Medical supplies such as dressings and antiseptics.</li> <li>Reusable devices such as blood glucose monitors and lancet cartridges.</li> <li>Diabetes supplies such as blood glucose test strips, lancets, syringes and needles.</li> <li>Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate.</li> <li>Brand-name drugs requested by a Member when there is a generic equivalent.</li> <li>Prescribed drugs that are necessary for or associated with excluded or non-covered services.</li> <li>Drugs related to sexual dysfunction.</li> <li>Drugs to shorten the duration of the common cold.</li> <li>Drugs related to enhancing athletic performance (such as weight training and body building).</li> <li>Any packaging other than the dispensing pharmacy's standard packaging.</li> <li>Immunizations, including travel immunizations.</li> <li>Contraceptive drugs and devices (to prevent unwanted pregnancies).</li> <li>Abortion drugs (such as RU-486).</li> <li>Replacement of lost, stolen or damaged drugs.</li> </ul>	\$20 per prescription

## Questions and answers about the drug benefit for the KP 20/Rx 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 \$20 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. Unless otherwise directed by Kaiser Permanente, refills may be allowed when 75% of the current prescription supply is taken/administered according to prescriber's directions.

### 6. *How do I receive prescriptions by mail?*

Save time and money on refills! If you have prescription drug coverage, you can get a 90-day supply of qualified prescription drugs covered under your drug rider for the price of 60 by using our convenient mail order service\*. And we pay the postage!

You can order your refills at your convenience, 24/7, using one of the methods below.

- For the quickest turnaround time, order online at [kp.org](http://kp.org).
- Order via our automated prescription refill service by calling 432-7979 (Oahu) or 1-888-867-2118 (Neighbor Islands). You'll have the following options:
  - To check your order status, press 1.
  - To order refills, press 2. You will be asked to enter your medical record number and prescription number. Then you'll have the option of receiving your refills via mail order (by pressing 1) or picking up your refills at one of our locations (by pressing 2)
  - To listen to detailed instructions, press 3.
- Order using our mail-order envelope, available at all Kaiser Permanente clinic locations.
- Order via our Pharmacy Refill Center at (808) 432-5510 (Oahu), or toll free 1-866-250-1805 (Neighbor Islands), Monday to Friday, 8:30 a.m. to 5 p.m. TTY users may call 1-877-447-5990.

So the next time you've used two-thirds of your existing supply of prescription medications, try using one of these convenient options.

If you must pick up your prescriptions at a clinic pharmacy, refillable prescriptions are usually ready for pickup at the designated pharmacy in one business day. Prescriptions requiring a physician's approval are usually ready in two business days. Call the pharmacy or Kaiser Permanente Hawaii's automated prescription refill line in advance to make sure that your prescription is ready. Orders not picked up within one week are returned to stock.

\*We are not licensed to mail medications out of state. There are restrictions for delivery of certain medications and supplies, including but not limited to controlled medications, injections, medications affected by temperature, and medications excluded by Kaiser Permanente's Pharmacy & Therapeutic Committee.



Section	Benefits	You pay
<b>Optical benefit \$150 for KP 20/Rx Plan</b>	<p><b>When prescription is filled at Kaiser Permanente Optical Center:</b></p> <p>Allowance may be used toward the following eyewear and services</p> <ul style="list-style-type: none"> <li>Glasses frames/lens/lens treatment ✦</li> </ul> <p style="text-align: center;"><b>Or</b></p> <ul style="list-style-type: none"> <li>Contact lens/contact lens exam and fitting services</li> </ul> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>The \$150 allowance is a one-time benefit per calendar year. If the entire allowance is not used during your initial visit any unused portion of the allowance cannot be used for the remainder of that calendar year and will not be carried forward to the next calendar year.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>Contact lenses or lenses, not medically required</li> <li>Non-prescription eyewear such as cosmetic colored contact lenses, non-prescription athletic, industrial safety and sunglass eyewear</li> <li>Any medical services or eyewear from non-Kaiser Permanente providers or non-Kaiser Permanente optical facilities</li> <li>Contact lens exams (if the \$150 allowance has been exhausted)</li> <li>All costs exceeding the \$150 allowance</li> </ul>	<p><b>All costs greater than the \$150 allowance once every calendar year</b></p>

✦ For members who are 18 years of age and under, the lens material will be impact resistant polycarbonate.

## Active&Fit® Program provides these extra services

Active&Fit	Services	You pay
	<b><u>Basic Program fitness club and exercise center membership program</u></b>	\$100 per calendar year <sup>+</sup>
	<ul style="list-style-type: none"><li>• Eligible Members may enroll with an American Specialty Health Networks, Inc. (ASH) contracted network fitness club</li><li>• Program enrollment includes standard fitness club services and features</li><li>• Eligible Members should verify services and features with the ASH contracted fitness club</li></ul>	
	<b>Or</b>	
	<b><u>Home Fitness Program</u></b>	\$10 per calendar year <sup>+</sup>
	<ul style="list-style-type: none"><li>• Eligible Members may select up to two of the available ASH home fitness kits per calendar year</li></ul>	
	<b><u>Active&amp;Fit website</u></b>	
	<ul style="list-style-type: none"><li>• All eligible Members have access to Active&amp;Fit web-based services such as facility provider search, enrollment functions, educational content and fitness tools and trackers.</li></ul>	
	The following are excluded from the Active&Fit Program:	
	<ul style="list-style-type: none"><li>• Personal trainers, classes, and club services, amenities, and products or supplies that are not routinely included in the general membership</li><li>• Access to fitness or exercise clubs that are not part of ASH's contracted network.</li><li>• Home fitness kits not provided through ASH's Active&amp;Fit program.</li><li>• Members who are eligible for Medicare are not eligible for this program.</li><li>• Enrollment for Members not specifically listed as eligible for this program.</li><li>• Enrollment for Members under the age of 16.</li></ul>	

<sup>+</sup> Members must pay their \$100 or \$10 fee directly to ASH prior to using services. There will be no refunds, and fees are not prorated. Fees do not count toward the eligible Member's health benefit plan's Supplemental Charges Maximum.

## Questions and answers about the Active&Fit Program

### 1. How do I sign up for the Active&Fit Program?

Members can enroll online at: [kp.org/activeandfit](http://kp.org/activeandfit) or by calling the American Specialty Health Network Active&Fit toll-free member services hotline at 1-877-750-2746, from 5 a.m. to 5 p.m. (Hawaii Time), Monday through Friday.

Note: Payment will be taken at time of enrollment in the Active&Fit program.

### 2. If I sign up mid-year, is my fee prorated?

No, the \$100 or \$10 fees will not be prorated, nor are they refundable.

### 3. Does the \$100 or \$10 fee count toward my out-of-pocket maximum?

The Active&Fit program is not a medical benefit, and therefore their \$100 or \$10 fee does not count towards your health plan out-of-pocket maximum.

**4. Does an Active&Fit member get an ID card? If so, how is one obtained?**

Yes. Within five days of enrollment in the program, ASH Networks will mail the member ID card in the member's Active&Fit enrollment kit. The member can take that ID card to the fitness facility that they chose.

**5. If a member is participating in the Home Fitness Program and changes his/her mind and wants to join a fitness facility, how long must the member wait before he/she can join a facility?**

Members may call the toll-free member services hotline at any time to enroll with a fitness facility by paying the \$100 fee. His/her effective date will be the first of the following month. The member will no longer receive the Active&Fit Home Fitness Kits.

**6. If a member is participating in the Gym program and then changes his/her mind and wants the Active&Fit Home Fitness Program, does the member get reimbursed the \$100 gym fee?**

No. The member will not get reimbursed the \$100 gym fee. In addition, he/she will need to pay the \$10 Home Fitness Program fee in order to receive their Home Fitness Kits.

**7. If a member is participating in the Active&Fit Home Fitness Program and then changes his/her mind and joins a facility, does the member need to return the Home Fitness Kits?**

No. The member may keep the Active&Fit home fitness kits. However, the member will have to pay the \$100 gym fee, and will not get reimbursed the \$10 home fitness fee.

**8. Does the member get a discount on the Gym Program since they already paid a fee for the Home Fitness Program?**

No, the member must pay the \$100 fee in full.

**9. Is this program available outside of the Hawaii service area?**

Yes, members may use their Active&Fit gym membership on the mainland when they travel. The member must call ASHN prior to traveling to register at another gym/facility.

**10. If a member chooses the Active&Fit Home Fitness Program during the enrollment process, how long will it take for the home fitness kits to arrive?**

The kits will be mailed within 30 days of enrollment.

## Kaiser Permanente 30/Rx Plan 2012 Benefits summary

**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 Non-Group Medical and Hospital Service Agreement, benefit schedule, and Riders (collectively known as “Service Agreement”). The Service Agreement is the legally 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
<b>Outpatient services</b>	<b>Primary care and specialty care office visits</b> (office visits are limited to one or more of the following services: exam, history, medical decision making) †  <i>Choice of primary care providers and access to specialty care:</i> <ul style="list-style-type: none"> <li>• Member may choose any primary care physician available to accept Member.</li> <li>• Parents may choose a pediatrician as the primary care physician for their child.</li> <li>• Members do not need a referral or prior authorization for certain specialty care, such as Gynecological care.</li> <li>• The physician may have to get prior authorization for certain services.</li> </ul> <ul style="list-style-type: none"> <li>• Eye examinations for eyeglasses *</li> <li>• Ear examinations to determine the need for hearing correction</li> </ul>	\$30 per visit (limited to 5 office visits per calendar year)
	<b>Outpatient surgery and procedures</b>	\$30 per visit (in doctor's office)  \$250 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<b>Preventive care services</b> (which protect against disease, promote health, and/or detect disease in its earliest stages before noticeable symptoms develop)  <i>A list of preventive care services provided at no charge is available through the Customer Service Center. This list is subject to change at any time. If you receive any other covered services during a preventive care visit, you will pay the applicable charges for those services.</i>	No charge (non-preventive care services according to member's regular plan benefits)
	<b>Preventive care office visits for:</b> <ul style="list-style-type: none"> <li>• Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, and 5 years)</li> <li>• One preventive care office visit per calendar year for members over 5 years of age †</li> <li>• One gynecological office visit per calendar year for female members †</li> </ul>	No charge
	<b>Routine immunizations</b>	No charge
	<b>Unexpected mass immunizations</b>	50% of applicable charges
	<b>Short-term physical, occupational and speech therapy ** †</b> (only if the condition is subject to significant, measurable improvement in physical	\$30 per visit

† An office visit related to the provided care counts toward the 5 office visit limit per calendar year. However, an office visit required by state or federal law does not count toward the limit.

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
	function; Kaiser Permanente clinical guidelines apply)	
<b>Outpatient services</b> (continued)	<b>Dialysis †</b> <ul style="list-style-type: none"> <li>Kaiser Permanente physician and facility services for dialysis</li> <li>Equipment, training and medical supplies for home dialysis</li> </ul>	10% of applicable charges No charge
	<b>Materials for dressings and casts</b>	No charge
<b>Hospital inpatient care</b> (for acute care registered bed patients)	<b>Hospital inpatient care</b> includes services such as: <ul style="list-style-type: none"> <li>Room and board</li> <li>General nursing care and special duty nursing</li> <li>Physicians' services</li> <li>Surgical procedures</li> <li>Respiratory therapy and radiation therapy</li> <li>Anesthesia</li> <li>Medical supplies</li> <li>Use of operating and recovery rooms</li> <li>Intensive care room</li> </ul>	\$450 per day
	<b>Short-term physical, occupational and speech therapy **</b> (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
	<b>Materials for dressings and casts</b>	No charge
<b>Laboratory, imaging, and testing services</b>	<b><u>Inpatient</u> laboratory services, imaging services, and testing services</b> <b><u>Outpatient</u> laboratory services, imaging services, and testing services</b>	No charge 50% of applicable charges
<b>Transplants</b>	<b>Transplants</b> , 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.)
<b>Prescribed drugs †</b>	<b>Prescribed drugs that require skilled administration by medical personnel</b> (e.g. cannot be self-administered) which meet all of the following: <ul style="list-style-type: none"> <li>Prescribed by a Kaiser Permanente licensed prescriber,</li> <li>On the Health Plan formulary and used in accordance with formulary criteria, guidelines or restrictions, and</li> <li>Prescription is required by law</li> </ul>	No charge ▼
	<b>Diabetes supplies **</b>	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)
	<b>Tobacco cessation drugs and products **</b>	No charge
	<b>Immunizations</b> are described in the outpatient services section	
	<b>Contraceptive drugs and devices</b> are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section	
	<b>Exclusion:</b> Drugs that are necessary or associated with services that are excluded or not covered	

† An office visit related to the provided care counts toward the 5 office visit limit per calendar year. However, an office visit required by state or federal law does not count toward the limit.

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services</b>	<b>Obstetrical (maternity) care</b>	
	<ul style="list-style-type: none"> <li>All maternity care is <u>not covered</u> (such as prenatal visits, delivery/hospital stay, post-partum visits, related labs and diagnostic imaging, etc.)</li> </ul>	All charges (maternity care is not covered)
	<b>Inpatient stay and inpatient care for newborn</b> 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)
	<b>Interrupted pregnancy</b>	
	<ul style="list-style-type: none"> <li>Medically indicated abortions</li> </ul>	\$30 per visit (in doctor's office)  \$250 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<ul style="list-style-type: none"> <li>Elective abortions (including abortion drugs such as RU-486) limited to two per member per lifetime</li> </ul>	\$30 per visit (in doctor's office)  \$250 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<b>Family planning office visits †</b>	\$30 per visit
	<b>FDA approved contraceptive drugs and devices **</b> (to prevent unwanted pregnancies) †	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply) ▼
	<b>Involuntary infertility office visits †</b>	\$30 per visit
	<b>Artificial insemination * †</b>	\$30 per visit
<b>Home health care and hospice care</b>	<b>In vitro fertilization *</b>	20% of applicable charges
	<ul style="list-style-type: none"> <li>Limited to one-time only benefit at Kaiser Permanente</li> <li>Limited to female members using spouse's sperm</li> </ul>	
<b>Home health care and hospice care</b>	<b>Home health care</b> , nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	No charge
	<b>Hospice care</b> . 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: <ul style="list-style-type: none"> <li>Nursing care (excluding private duty nursing)</li> <li>Medical social services</li> <li>Home health aide services</li> <li>Medical supplies</li> <li>Kaiser Permanente physician services</li> <li>Counseling and coordination of bereavement services</li> <li>Services of volunteers</li> <li>Physical therapy, occupational therapy, or speech language pathology</li> </ul>	No charge

† An office visit related to the provided care counts toward the 5 office visit limit per calendar year. However, an office visit required by state or federal law does not count toward the limit.

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Skilled nursing care</b>	<p>Up to <b>60 days of prescribed skilled nursing care services in an approved facility</b> (such as a hospital or skilled nursing facility) <b>per benefit period</b>. Covered services include nursing care, room and board, medical social services, medical supplies, and durable medical equipment ordinarily provided by a skilled nursing facility.</p> <p>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.</p> <p><b>Exclusions:</b> Personal comfort items, such as telephone, television and take-home medical supplies.</p>	No charge
<b>Emergency services ▲</b> (covered for initial emergency treatment only)	<p>At a facility <u>within</u> the Hawaii service area for covered emergency services</p> <p>At a facility <u>outside</u> the Hawaii service area for covered emergency services</p> <p>Note: Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility.</p> <p>▲ <i>Emergency Services are those medically necessary services available through the emergency department to medically screen, examine and Stabilize the patient for Emergency Medical Conditions. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity that meet the prudent layperson standard and the absence of immediate medical attention will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or place the health of the individual in serious jeopardy. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.</i></p>	<p>\$100 copay per visit</p> <p>\$100 copay per visit</p>
<b>Urgent care services</b>	<p>At a Kaiser (or Kaiser-designated) urgent care center within the Hawaii service area for covered urgent care services †</p> <p>At a non-Kaiser Permanente facility outside the Hawaii service area for covered urgent care services</p> <p>(Coverage for initial urgent care treatment only) ♦</p> <p>♦ <i>"Urgent Care Services" means medically necessary services for a condition that requires prompt medical attention but is not an Emergency Medical Condition. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.</i></p>	<p>\$30 per visit</p> <p>20% of applicable charges</p>
<b>Ambulance services</b>	<p>Ambulance Services are those services in which:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Is for the purpose of transporting the member to receive medically necessary acute care.</li> </ul> <p>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.</p>	20% of applicable charges
<b>Blood</b>	<p>Regardless of replacement, units and processing of units of <b>whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin</b></p> <p>Collection, processing, and storage of <b>autologous blood</b> when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used</p>	<p>No charge</p> <p>No charge</p>

† An office visit related to the provided care counts toward the 5 office visit limit per calendar year. However, an office visit required by state or federal law does not count toward the limit.

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Mental health services *</b> for serious mental illness	<p>“Serious mental illness” includes schizophrenia, schizo-affective disorder, bipolar types I and II, delusional disorder, major depression, obsessive-compulsive disorder, and dissociative disorder.</p> <p>Outpatient office visits</p> <p>Hospital inpatient care</p>	<p>\$30 per visit</p> <p>\$450 per day</p>
<b>Mental health services *</b> for non-serious mental illness	<p><b>Up to 24 outpatient office visits per calendar year</b></p> <ul style="list-style-type: none"> <li>Psychological testing * as part of diagnostic evaluation, when ordered by a Kaiser Permanente physician or psychologist</li> </ul> <p><b>Additional outpatient office visits</b> 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</p> <p><b>Up to 30 days of hospital care per calendar year</b> 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.)</p> <ul style="list-style-type: none"> <li>Hospital care Services of Kaiser Permanente physicians, mental health professionals and other health care professionals, or Kaiser Permanente physician's visits in specialized facility</li> <li>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</li> </ul>	<p>20% of applicable charges</p> <p>20% of applicable charges</p> <p>20% of applicable charges</p> <p>20% of applicable charges</p> <p>20% of applicable charges</p>
<b>Chemical dependency services **</b>	<p>Outpatient office visits</p> <p>Hospital inpatient care</p> <p>Up to 60 days per calendar year of residential chemical dependency services *</p>	<p>\$30 per visit</p> <p>\$450 per day</p> <p>20% of applicable charges</p>
<b>Internal prosthetics, devices, and aids</b>	<p><b>Implanted internal prosthetics</b> (such as pacemakers and hip joints), <b>and internally implanted devices and aids</b> (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</p> <p>Fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss</p> <p><b>Internal prosthetics</b> are those which meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>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,</li> <li>Are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA),</li> <li>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</li> <li>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.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>All implanted internal prosthetics and devices and internally implanted aids related to an excluded or non-covered service/benefit</li> <li>Prosthetics, devices, and aids related to sexual dysfunction</li> </ul> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>Coverage is limited to the standard prosthetic model that adequately meets the medical needs of the</li> </ul>	<p>No charge</p> <p>No charge</p>

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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
Member. Convenience and luxury items and features are not covered.		
<b>Diabetes and home phototherapy equipment</b>	<b>Diabetes equipment</b> (limited to blood glucose monitors 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	50% of applicable charges
	<b>Home phototherapy equipment for newborns</b> 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	No charge
	<p><b>Diabetes and home phototherapy equipment</b> is that equipment and supplies necessary to operate the equipment which:</p> <ul style="list-style-type: none"> <li>• Is intended for repeated use,</li> <li>• Is primarily and customarily used to serve a medical purpose,</li> <li>• Is appropriate for use in the home,</li> <li>• Is generally not useful to a person in the absence of illness or injury,</li> <li>• 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,</li> <li>• 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</li> <li>• Is on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Comfort and convenience equipment, and devices not medical in nature.</li> <li>• Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages.</li> <li>• Repair, adjustment or replacement due to misuse or loss.</li> <li>• Experimental or research equipment.</li> </ul> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>• If rented or loaned from Health Plan, the Member must return any diabetes or home phototherapy 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.</li> <li>• Coverage is limited to the standard item of diabetes or home phototherapy equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.</li> </ul>	

† An office visit related to the provided care counts toward the 5 office visit limit per calendar year. However, an office visit required by state or federal law does not count toward the limit.

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Supplemental charges maximum</b>	<p><b>Your out-of-pocket expenses for covered Basic Health Services are capped each year by a supplemental charges maximum.</b></p> <p><i><b>YOU MUST RETAIN YOUR RECEIPTS</b></i> for these supplemental charges and when that maximum amount has been <b>PAID</b>, 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 <b>PAID</b>, <b>you will be given a card</b> 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 <b>show this card</b> 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. <b>All payments are credited toward the calendar year in which the medical services were received.</b></p> <p>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.</p> <p>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.</p> <p><b>Supplemental charges for the following covered Basic Health Services</b> 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.</p> <p>These are not Basic Health Services and charges for these services/items are <b>not</b> 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.</p>	\$4,000 per member

† An office visit related to the provided care counts toward the 5 office visit limit per calendar year. However, an office visit required by state or federal law does not count toward the limit.

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

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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 external prosthetic devices and braces portion of this exclusion may not apply if you have an External Prosthetic Devices and Braces Rider. The hearing aids portion of this exclusion may not apply if you have a Hearing Aid Rider. The eyeglasses and contact lens portion of this exclusion may not apply if you have an Optical 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, including treatment for complications resulting from cosmetic services. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery, incident to a covered mastectomy, or cosmetic service provided by a Physician in a Health Plan facility 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 blood glucose monitors 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 vision therapy, including orthoptics, visual training and **eye exercises**.
- **Eye surgery** solely for the purpose of correcting refractive defects of the eye, such as Radial Keratotomy (RK), and Photo-refractive keratectomy (PRK).
- **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.
- 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.**

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## \*\* 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.
- Up to a 30-consecutive-day supply of **diabetes supplies** is provided (as described under the **prescribed drugs** section) if all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate.
- 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.
- Up to a 30-consecutive-day supply of **tobacco cessation drugs and products** is provided when all of the following criteria are met: 1) available on the Health Plan formulary's Tobacco Cessation list of approved drugs and products, including over-the-counter drugs and products, and in accordance with formulary criteria, guidelines, or restrictions, 2) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate, and 3) Member meets Health Plan-approved program-defined requirements for smoking cessation classes or counseling (tobacco cessation classes and counseling sessions are provided at no charge).
- **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 Kaiser Permanente 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.

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### 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
<b>Drug benefit 30 for KP 30/Rx Plan</b>	<b>For each prescription, when the quantity does not exceed:</b> <ul style="list-style-type: none"> <li>a 30–consecutive-day supply of a prescribed drug, or</li> <li>an amount as determined by the formulary.</li> </ul>	\$30 per prescription
	<b>Self-administered drugs</b> are covered only when all of the following criteria are met: <ul style="list-style-type: none"> <li>prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate,</li> <li>on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions,</li> <li>the drug is one for which a prescription is required by law,</li> <li>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</li> <li>drug does not require administration by nor observation by medical personnel.</li> </ul>	
	<b>Insulin</b>	\$30 per prescription
	<b>Diabetes supplies and tobacco cessation drugs and products</b> are described in the prescribed drugs section	
	<b>Contraceptive drugs and devices</b> are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section	
	<b>Exclusions:</b> <ul style="list-style-type: none"> <li>Drugs related to obstetrical (maternity) care.</li> <li>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. This exclusion does not apply to tobacco cessation drugs and products as described in the prescribed drugs section.</li> <li>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.</li> <li>Drugs obtained from a non-Kaiser Permanente pharmacy.</li> <li>Non-prescription vitamins.</li> <li>Drugs when used primarily for cosmetic purposes.</li> <li>Medical supplies such as dressings and antiseptics.</li> <li>Reusable devices such as blood glucose monitors and lancet cartridges.</li> <li>Diabetes supplies such as blood glucose test strips, lancets, syringes and needles.</li> <li>Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate.</li> <li>Brand-name drugs requested by a Member when there is a generic equivalent.</li> <li>Prescribed drugs that are necessary for or associated with excluded or non-covered services.</li> <li>Drugs related to sexual dysfunction.</li> <li>Drugs to shorten the duration of the common cold.</li> <li>Drugs related to enhancing athletic performance (such as weight training and body building).</li> <li>Any packaging other than the dispensing pharmacy's standard packaging.</li> <li>Immunizations, including travel immunizations.</li> <li>Contraceptive drugs and devices (to prevent unwanted pregnancies).</li> <li>Abortion drugs (such as RU-486).</li> <li>Replacement of lost, stolen or damaged drugs.</li> </ul>	

## Questions and answers about the drug benefit for the KP 30/Rx 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 \$30 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. Unless otherwise directed by Kaiser Permanente, refills may be allowed when 75% of the current prescription supply is taken/administered according to prescriber's directions.

### 6. *How do I receive prescriptions by mail?*

Save time and money on refills! If you have prescription drug coverage, you can get a 90-day supply of qualified prescription drugs covered under your drug rider for the price of 60 by using our convenient mail order service\*. And we pay the postage!

You can order your refills at your convenience, 24/7, using one of the methods below.

- For the quickest turnaround time, order online at [kp.org](http://kp.org).
- Order via our automated prescription refill service by calling 432-7979 (Oahu) or 1-888-867-2118 (Neighbor Islands). You'll have the following options:
  - To check your order status, press 1.
  - To order refills, press 2. You will be asked to enter your medical record number and prescription number. Then you'll have the option of receiving your refills via mail order (by pressing 1) or picking up your refills at one of our locations (by pressing 2)
  - To listen to detailed instructions, press 3.
- Order using our mail-order envelope, available at all Kaiser Permanente clinic locations.
- Order via our Pharmacy Refill Center at (808) 432-5510 (Oahu), or toll free 1-866-250-1805 (Neighbor Islands), Monday to Friday, 8:30 a.m. to 5 p.m. TTY users may call 1-877-447-5990.

So the next time you've used two-thirds of your existing supply of prescription medications, try using one of these convenient options.

If you must pick up your prescriptions at a clinic pharmacy, refillable prescriptions are usually ready for pickup at the designated pharmacy in one business day. Prescriptions requiring a physician's approval are usually ready in two business days. Call the pharmacy or Kaiser Permanente Hawaii's automated prescription refill line in advance to make sure that your prescription is ready. Orders not picked up within one week are returned to stock.

\*We are not licensed to mail medications out of state. There are restrictions for delivery of certain medications and supplies, including but not limited to controlled medications, injections, medications affected by temperature, and medications excluded by Kaiser Permanente's Pharmacy & Therapeutic Committee.



## Active&Fit® Program provides these extra services

Active&Fit	Services	You pay
	<b><u>Basic Program fitness club and exercise center membership program</u></b>	\$100 per calendar year <sup>+</sup>
	<ul style="list-style-type: none"><li>• Eligible Members may enroll with an American Specialty Health Networks, Inc. (ASH) contracted network fitness club</li><li>• Program enrollment includes standard fitness club services and features</li><li>• Eligible Members should verify services and features with the ASH contracted fitness club</li></ul>	
	<b>Or</b>	
	<b><u>Home Fitness Program</u></b>	\$10 per calendar year <sup>+</sup>
	<ul style="list-style-type: none"><li>• Eligible Members may select up to two of the available ASH home fitness kits per calendar year</li></ul>	
	<b><u>Active&amp;Fit website</u></b>	
	<ul style="list-style-type: none"><li>• All eligible Members have access to Active&amp;Fit web-based services such as facility provider search, enrollment functions, educational content and fitness tools and trackers.</li></ul>	
	The following are excluded from the Active&Fit Program:	
	<ul style="list-style-type: none"><li>• Personal trainers, classes, and club services, amenities, and products or supplies that are not routinely included in the general membership</li><li>• Access to fitness or exercise clubs that are not part of ASH's contracted network.</li><li>• Home fitness kits not provided through ASH's Active&amp;Fit program.</li><li>• Members who are eligible for Medicare are not eligible for this program.</li><li>• Enrollment for Members not specifically listed as eligible for this program.</li><li>• Enrollment for Members under the age of 16.</li></ul>	

<sup>+</sup> Members must pay their \$100 or \$10 fee directly to ASH prior to using services. There will be no refunds, and fees are not prorated. Fees do not count toward the eligible Member's health benefit plan's Supplemental Charges Maximum.

## Questions and answers about the Active&Fit Program

### 1. How do I sign up for the Active&Fit Program?

Members can enroll online at: [kp.org/activeandfit](http://kp.org/activeandfit) or by calling the American Specialty Health Network Active&Fit toll-free member services hotline at 1-877-750-2746, from 5 a.m. to 5 p.m. (Hawaii Time), Monday through Friday.

Note: Payment will be taken at time of enrollment in the Active&Fit program.

### 2. If I sign up mid-year, is my fee prorated?

No, the \$100 or \$10 fees will not be prorated, nor are they refundable.

### 3. Does the \$100 or \$10 fee count toward my out-of-pocket maximum?

The Active&Fit program is not a medical benefit, and therefore their \$100 or \$10 fee does not count towards your health plan out-of-pocket maximum.

**4. Does an Active&Fit member get an ID card? If so, how is one obtained?**

Yes. Within five days of enrollment in the program, ASH Networks will mail the member ID card in the member's Active&Fit enrollment kit. The member can take that ID card to the fitness facility that they chose.

**5. If a member is participating in the Home Fitness Program and changes his/her mind and wants to join a fitness facility, how long must the member wait before he/she can join a facility?**

Members may call the toll-free member services hotline at any time to enroll with a fitness facility by paying the \$100 fee. His/her effective date will be the first of the following month. The member will no longer receive the Active&Fit Home Fitness Kits.

**6. If a member is participating in the Gym program and then changes his/her mind and wants the Active&Fit Home Fitness Program, does the member get reimbursed the \$100 gym fee?**

No. The member will not get reimbursed the \$100 gym fee. In addition, he/she will need to pay the \$10 Home Fitness Program fee in order to receive their Home Fitness Kits.

**7. If a member is participating in the Active&Fit Home Fitness Program and then changes his/her mind and joins a facility, does the member need to return the Home Fitness Kits?**

No. The member may keep the Active&Fit home fitness kits. However, the member will have to pay the \$100 gym fee, and will not get reimbursed the \$10 home fitness fee.

**8. Does the member get a discount on the Gym Program since they already paid a fee for the Home Fitness Program?**

No, the member must pay the \$100 fee in full.

**9. Is this program available outside of the Hawaii service area?**

Yes, members may use their Active&Fit gym membership on the mainland when they travel. The member must call ASHN prior to traveling to register at another gym/facility.

**10. If a member chooses the Active&Fit Home Fitness Program during the enrollment process, how long will it take for the home fitness kits to arrive?**

The kits will be mailed within 30 days of enrollment.

## Kaiser Permanente Basic Plan 2012 Benefits summary

**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 Non-Group Medical and Hospital Service Agreement, and benefit schedule (collectively known as “Service Agreement”). The Service Agreement is the legally 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 (such as hospitalization) need to be coordinated and authorized by a Kaiser Permanente physician, otherwise the services are not covered.

*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
<b>Outpatient services</b>	<b>Primary care and specialty care office visits</b>  <i>Choice of primary care providers and access to specialty care:</i> <ul style="list-style-type: none"> <li>• Member may choose any primary care physician available to accept Member.</li> <li>• Parents may choose a pediatrician as the primary care physician for their child.</li> <li>• Members do not need a referral or prior authorization for certain specialty care, such as Gynecological care.</li> <li>• The physician may have to get prior authorization for certain services.</li> </ul> <ul style="list-style-type: none"> <li>• Eye examinations for eyeglasses *</li> <li>• Ear examinations to determine the need for hearing correction *</li> </ul>	All charges (not covered)
	<b>Outpatient surgery and procedures</b>	All charges (not covered) ‡  \$500 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<b>Preventive care services</b> (which protect against disease, promote health, and/or detect disease in its earliest stages before noticeable symptoms develop)  <i>A list of preventive care services provided at no charge is available through the Customer Service Center. This list is subject to change at any time. If you receive any other covered services during a preventive care visit, you will pay the applicable charges for those services.</i>	No charge (non-preventive care services according to member's regular plan benefits)
	<b>Preventive care office visits for:</b> <ul style="list-style-type: none"> <li>• Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, and 5 years)</li> <li>• One preventive care office visit for members over years of age (or one routine gynecological office visit for female members) per calendar year</li> </ul>	No charge
	Diabetes self-management training and education	\$30 per visit
	Treatment of physical complications of all stages of mastectomy, including lymphedemas	\$30 per visit
	Office visits in connection with a covered surgery, both pre- and post-operation	\$30 per visit
	<b>Routine immunizations</b>	No charge
	<b>Unexpected mass immunizations</b>	50% of applicable charges

‡ However, when provided in a hospital-based setting, Ambulatory Surgery Center (ASC), or reconstructive surgery related to a covered mastectomy, you pay the following copay: a) \$500 per procedure episode per day for outpatient surgery and procedures, b) no charge for skilled administered drugs and materials for dressings and casts, c) no charge for blood, and d) no charge for internal prosthetics, devices and aids.

\* See Coverage Exclusions Section

\*\* See Coverage Limitations Section

Section	Benefits	You pay
	<b>Short-term physical, occupational and speech therapy **</b> (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply)	All charges (not covered)
	<b>Dialysis</b>	
	• Kaiser Permanente physician and facility services for dialysis	All charges (not covered)
	• Equipment, training and medical supplies for home dialysis	All charges (not covered)
	<b>Materials for dressings and casts</b>	All charges (not covered) ‡
<b>Hospital inpatient care</b> (for acute care registered bed patients)	<b>Hospital inpatient care</b> includes services such as: <ul style="list-style-type: none"> <li>• Room and board</li> <li>• General nursing care and special duty nursing</li> <li>• Physicians' services</li> <li>• Surgical procedures</li> <li>• Respiratory therapy and radiation therapy</li> <li>• Anesthesia</li> <li>• Medical supplies</li> <li>• Use of operating and recovery rooms</li> <li>• Intensive care room</li> <li>• Blood</li> <li>• Internal prosthetics, devices, and aids</li> </ul> <b>Short-term physical, occupational and speech therapy **</b> (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply)	\$500 per day
	<b>Materials for dressings and casts</b>	Included in the above hospital inpatient care copay
<b>Laboratory, imaging, and testing services</b>	<b>Inpatient laboratory services, imaging services, and testing services</b>	No charge
	<b>Outpatient laboratory services, imaging services, and testing services</b>	All charges (not covered)
<b>Transplants</b>	<b>All transplants</b> and related care/services *	All charges (not covered)
<b>Prescribed drugs</b>	<b>Prescribed drugs that require skilled administration by medical personnel</b> ‡ (e.g. cannot be self-administered) which meet all of the following: <ul style="list-style-type: none"> <li>• Prescribed by a Kaiser Permanente licensed prescriber,</li> <li>• On the Health Plan formulary and used in accordance with formulary criteria, guidelines or restrictions, and</li> <li>• Prescription is required by law</li> </ul> <b>Diabetes supplies **</b>	All charges (not covered)
	<b>Tobacco cessation drugs and products **</b>	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)
	<b>Immunizations</b> are described in the outpatient services section	No charge
	<b>Contraceptive drugs and devices</b> are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section	
	<b>Exclusions:</b> <ul style="list-style-type: none"> <li>• Self-administered drugs (such as drugs taken orally)</li> <li>• Drugs that are necessary or associated with services that are excluded or not covered</li> </ul>	

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\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services</b>	<b>Obstetrical (maternity) care</b>	
	<ul style="list-style-type: none"> <li>All maternity care is <u>not covered</u> (such as prenatal visits, delivery/hospital stay, post-partum visits, related labs and diagnostic imaging, etc.)</li> </ul>	All charges (not covered)
	<b>Inpatient stay and inpatient care for newborn</b> 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)
	<b>Interrupted pregnancy</b>	
	<ul style="list-style-type: none"> <li>Medically indicated abortions</li> </ul>	Office visits not covered.  \$500 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<ul style="list-style-type: none"> <li>Elective abortions (including abortion drugs such as RU-486) limited to two per member per lifetime</li> </ul>	Office visits not covered.  \$500 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<b>Family planning office visits</b>	All charges
	<b>FDA approved contraceptive drugs and devices **</b> (to prevent unwanted pregnancies)	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply); (If ordered during the covered one routine physical exam (or routine gynecological visit), then no charge for the office visit; otherwise the office visit is not covered and member pays all charges)
	<b>Involuntary infertility office visits</b>	All charges (not covered)
	<b>Artificial insemination *</b>	All charges (not covered)
	<b>In vitro fertilization *</b>	20% of applicable charges
	<ul style="list-style-type: none"> <li>Limited to one-time only benefit at Kaiser Permanente</li> <li>Limited to female members using spouse's sperm</li> </ul>	

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\* See **Coverage Exclusions** Section

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Section	Benefits	You pay
<b>Home health care and hospice care</b>	<b>Home health care.</b> nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	No charge
	<b>Hospice care.</b> 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: <ul style="list-style-type: none"> <li>• Nursing care (excluding private duty nursing)</li> <li>• Medical social services</li> <li>• Home health aide services</li> <li>• Medical supplies</li> <li>• Kaiser Permanente physician services</li> <li>• Counseling and coordination of bereavement services</li> <li>• Services of volunteers</li> <li>• Physical therapy, occupational therapy, or speech language pathology</li> </ul>	No charge
<b>Skilled nursing care</b>	Up to <b>60 days of prescribed skilled nursing care services in an approved facility</b> (such as a hospital or skilled nursing facility) <b>per benefit period</b> . 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.  <b>Exclusions:</b> Personal comfort items, such as telephone, television and take-home medical supplies.	\$50 per day
<b>Emergency services</b> ▲ (covered for initial emergency treatment only)	At a facility <u>within</u> the Hawaii service area for covered emergency services	\$250 copay per visit Δ
	At a facility <u>outside</u> the Hawaii service area for covered emergency services  Note: Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility.  ▲ <i>Emergency Services are those medically necessary services available through the emergency department to medically screen, examine and Stabilize the patient for Emergency Medical Conditions. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity that meet the prudent layperson standard and the absence of immediate medical attention will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or place the health of the individual in serious jeopardy.</i> <b>Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.</b>  Δ <i>Covered services include blood; internal prosthetics, devices, and aids; skilled administered drugs; and materials for casts and dressings.</i>	\$250 copay per visit Δ
<b>Urgent care services</b>	At a Kaiser (or Kaiser-designated) urgent care center within the Hawaii service area for covered urgent care services	All charges (not covered)
	At a non-Kaiser Permanente facility outside the Hawaii service area for covered urgent care services (Coverage for initial urgent care treatment only) ❖  ❖ <i>"Urgent Care Services" means medically necessary services for a condition that requires prompt medical attention but is not an Emergency Medical Condition. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.</i>	20% of applicable charges

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- \* See **Coverage Exclusions** Section
- \*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Ambulance services</b>	<p>Ambulance Services are those services in which:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Is for the purpose of transporting the member to receive medically necessary acute care.</li> </ul> <p>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.</p>	20% of applicable charges
<b>Blood</b>	<p>Regardless of replacement, units and processing of units of <b>whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin</b></p> <p>Collection, processing, and storage of <b>autologous blood</b> when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used</p>	<p>All charges (not covered) ‡</p> <p>All charges (not covered) ‡</p>
<b>Mental health services *</b> for serious mental illness	<p>"Serious mental illness" includes schizophrenia, schizo-affective disorder, bipolar types I and II, delusional disorder, major depression, obsessive-compulsive disorder, and dissociative disorder.</p> <p>Up to 24 outpatient office visits (combined with mental health for non-serious mental illness and chemical dependency) per calendar year</p> <p>Hospital inpatient care</p>	<p>\$30 per visit</p> <p>\$500 per day</p>
<b>Mental health services *</b> for non-serious mental illness	<p>Up to 24 outpatient office visits (combined with mental health for serious mental illness and chemical dependency) per calendar year</p> <ul style="list-style-type: none"> <li>• Psychological testing * as part of diagnostic evaluation, when ordered by a Kaiser Permanente physician or psychologist</li> </ul> <p>Additional outpatient office visits</p> <p>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</p> <p>Up to 30 days of hospital care per calendar year</p> <p>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.)</p> <ul style="list-style-type: none"> <li>• Hospital care</li> <li>• Specialized facility services</li> </ul>	<p>\$30 per visit</p> <p>\$30 per visit</p> <p>\$30 per visit</p> <p>\$500 per day</p> <p>\$500 per day</p>
<b>Chemical dependency services */**</b>	<p>Up to 24 outpatient office visits (combined with mental health for serious and non-serious mental illness) per calendar year</p> <p>Hospital inpatient care</p> <p>Residential chemical dependency services</p>	<p>\$30 per visit</p> <p>\$500 per day</p> <p>All charges (not covered)</p>

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\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Internal prosthetics, devices, and aids</b>	<b>Implanted internal prosthetics</b> (such as pacemakers and hip joints), <b>and internally implanted devices and aids</b> (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	All charges (not covered) ‡
	Fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss	All charges (not covered) ‡
	<p><b>Internal prosthetics</b> are those which meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>• 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,</li> <li>• Are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA),</li> <li>• 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</li> <li>• 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.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• All implanted internal prosthetics and devices and internally implanted aids related to an excluded or non-covered service/benefit</li> <li>• Prosthetics, devices, and aids related to sexual dysfunction</li> </ul> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>	

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Section	Benefits	You pay
<b>Diabetes and home phototherapy equipment</b>	<b>Diabetes equipment</b> (limited to blood glucose monitors 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	50% of applicable charges
	<b>Home phototherapy equipment for newborns</b> 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	No charge
	<p><b>Diabetes and home phototherapy equipment</b> is that equipment and supplies necessary to operate the equipment which:</p> <ul style="list-style-type: none"> <li>• Is intended for repeated use,</li> <li>• Is primarily and customarily used to serve a medical purpose,</li> <li>• Is appropriate for use in the home,</li> <li>• Is generally not useful to a person in the absence of illness or injury,</li> <li>• 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,</li> <li>• 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</li> <li>• Is on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Comfort and convenience equipment, and devices not medical in nature.</li> <li>• Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages.</li> <li>• Repair, adjustment or replacement due to misuse or loss.</li> <li>• Experimental or research equipment.</li> </ul> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>• If rented or loaned from Health Plan, the Member must return any diabetes or home phototherapy 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.</li> <li>• Coverage is limited to the standard item of diabetes or home phototherapy equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.</li> </ul>	

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\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Supplemental charges maximum</b>	<p><b>Your out-of-pocket expenses for covered Basic Health Services are capped each year by a supplemental charges maximum.</b></p> <p><b><i>YOU MUST RETAIN YOUR RECEIPTS</i></b> for these supplemental charges and when that maximum amount has been <b>PAID</b>, 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 <b>PAID</b>, <b>you will be given a card</b> 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 <b>show this card</b> 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. <b>All payments are credited toward the calendar year in which the medical services were received.</b></p> <p>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.</p> <p>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.</p> <p><b>Supplemental charges for the following covered Basic Health Services</b> can be applied toward the supplemental charges maximum: your covered office visits for medical services listed in this Basic Health Services section, ambulance service, chemical dependency services (except residential services), drugs requiring skilled administration received during hospital inpatient care, emergency service, one routine physical exam (or routine gynecological office visit for female members), home health, inpatient imaging (including X-rays), immunizations (excluding travel immunizations), in vitro fertilization procedure (excluding drugs), inpatient room (semi-private), inpatient laboratory, mental health services for the first 24 outpatient visits and the first 30 inpatient visits, outpatient surgery and procedures, reconstructive surgery related to a covered mastectomy, inpatient short-term physical therapy, inpatient short-term speech therapy, inpatient short-term occupational therapy, inpatient testing services, and urgent care. When provided in a hospital-based setting, Ambulatory Surgery Center (ASC), reconstructive surgery related to a covered mastectomy, or incident to emergency services, these supplemental charges also can be applied toward the supplemental charges maximum: interrupted pregnancy/abortion and drugs requiring skilled administration.</p> <p>These are not Basic Health Services and charges for these services/items are <b>not</b> applicable towards the supplemental charges maximum: all services for which coverage has been exhausted, all excluded or non-covered benefits (such as obstetrical (maternity) care, artificial insemination, dialysis, family planning office visits, infertility office visits, all transplant services, primary care and specialty office visits, ear examinations, eye examinations, radiation therapy and respiratory therapy, outpatient imaging, outpatient laboratory, outpatient testing services, outpatient short-term physical therapy, outpatient short-term speech therapy, outpatient short-term occupational therapy), 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.</p>	\$5,000 per member

‡ However, when provided in a hospital-based setting, Ambulatory Surgery Center (ASC), or reconstructive surgery related to a covered mastectomy, you pay the following copay: a) \$500 per procedure episode per day for outpatient surgery and procedures, b) no charge for skilled administered drugs and materials for dressings and casts, c) no charge for blood, and d) no charge for internal prosthetics, devices and aids.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

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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.
- **Transplant Services.**
- **All outpatient care** (such as office visits, procedures, lab, imaging, testing) that are not specifically listed in this benefit summary as covered.
- **Dialysis Services** for acute renal failure and chronic renal disease.
- **Family planning Services.**
- **Involuntary infertility Services.**
- **Reconstructive surgery or procedures** performed in the Medical Office.
- **Primary care and specialty office visits.**
- **Ear examinations** to determine the need for hearing correction.
- **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 external prosthetic devices and braces portion of this exclusion may not apply if you have an External Prosthetic Devices and Braces Rider. The hearing aids portion of this exclusion may not apply if you have a Hearing Aid Rider. The eyeglasses and contact lens portion of this exclusion may not apply if you have an Optical 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, including treatment for complications resulting from cosmetic services. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery, incident to a covered mastectomy, or cosmetic service provided by a Physician in a Health Plan facility 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 blood glucose monitors 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 eye glasses and contact lenses (Eye exams for contact lens may be partially covered if you have an Optical Rider.) and vision therapy, including orthoptics, visual training and **eye exercises.**
- **Eye surgery** solely for the purpose of correcting refractive defects of the eye, such as Radial Keratotomy (RK), and Photo-refractive keratectomy (PRK).
- **Routine foot care**, unless medically necessary.
- **Health education:** general health education services, specialized health promotion classes and support groups (such as the bariatric surgery program).
- **Homemaker Services.**
- The following costs and Services for **in vitro fertilization:**
  - 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 in vitro fertilization, such as artificial insemination, 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.
- 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.**

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## **\*\* 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.
- Up to a 30-consecutive-day supply of **diabetes supplies** is provided (as described under the **prescribed drugs** section) if all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate.
- When provided while hospitalized, in a skilled nursing facility, or receiving home health care, 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.
- Up to a 30-consecutive-day supply of **tobacco cessation drugs and products** is provided when all of the following criteria are met: 1) available on the Health Plan formulary's Tobacco Cessation list of approved drugs and products, including over-the-counter drugs and products, and in accordance with formulary criteria, guidelines, or restrictions, 2) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate, and 3) Member meets Health Plan-approved program-defined requirements for smoking cessation classes or counseling (tobacco cessation classes and counseling sessions are provided at no charge).
- **Tuberculin skin test** is limited to one per calendar year, unless medically necessary.

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## **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.

## Active&Fit® Program provides these extra services

Active&Fit	Services	You pay
	<b><u>Basic Program fitness club and exercise center membership program</u></b>	\$100 per calendar year <sup>+</sup>
	<ul style="list-style-type: none"><li>• Eligible Members may enroll with an American Specialty Health Networks, Inc. (ASH) contracted network fitness club</li><li>• Program enrollment includes standard fitness club services and features</li><li>• Eligible Members should verify services and features with the ASH contracted fitness club</li></ul>	
	<b>Or</b>	
	<b><u>Home Fitness Program</u></b>	\$10 per calendar year <sup>+</sup>
	<ul style="list-style-type: none"><li>• Eligible Members may select up to two of the available ASH home fitness kits per calendar year</li></ul>	
	<b><u>Active&amp;Fit website</u></b>	
	<ul style="list-style-type: none"><li>• All eligible Members have access to Active&amp;Fit web-based services such as facility provider search, enrollment functions, educational content and fitness tools and trackers.</li></ul>	
	The following are excluded from the Active&Fit Program:	
	<ul style="list-style-type: none"><li>• Personal trainers, classes, and club services, amenities, and products or supplies that are not routinely included in the general membership</li><li>• Access to fitness or exercise clubs that are not part of ASH's contracted network.</li><li>• Home fitness kits not provided through ASH's Active&amp;Fit program.</li><li>• Members who are eligible for Medicare are not eligible for this program.</li><li>• Enrollment for Members not specifically listed as eligible for this program.</li><li>• Enrollment for Members under the age of 16.</li></ul>	

<sup>+</sup> Members must pay their \$100 or \$10 fee directly to ASH prior to using services. There will be no refunds, and fees are not prorated. Fees do not count toward the eligible Member's health benefit plan's Supplemental Charges Maximum.

## Questions and answers about the Active&Fit Program

### 1. How do I sign up for the Active&Fit Program?

Members can enroll online at: [kp.org/activeandfit](http://kp.org/activeandfit) or by calling the American Specialty Health Network Active&Fit toll-free member services hotline at 1-877-750-2746, from 5 a.m. to 5 p.m. (Hawaii Time), Monday through Friday.

Note: Payment will be taken at time of enrollment in the Active&Fit program.

### 2. If I sign up mid-year, is my fee prorated?

No, the \$100 or \$10 fees will not be prorated, nor are they refundable.

### 3. Does the \$100 or \$10 fee count toward my out-of-pocket maximum?

The Active&Fit program is not a medical benefit, and therefore their \$100 or \$10 fee does not count towards your health plan out-of-pocket maximum.

**4. Does an Active&Fit member get an ID card? If so, how is one obtained?**

Yes. Within five days of enrollment in the program, ASH Networks will mail the member ID card in the member's Active&Fit enrollment kit. The member can take that ID card to the fitness facility that they chose.

**5. If a member is participating in the Home Fitness Program and changes his/her mind and wants to join a fitness facility, how long must the member wait before he/she can join a facility?**

Members may call the toll-free member services hotline at any time to enroll with a fitness facility by paying the \$100 fee. His/her effective date will be the first of the following month. The member will no longer receive the Active&Fit Home Fitness Kits.

**6. If a member is participating in the Gym program and then changes his/her mind and wants the Active&Fit Home Fitness Program, does the member get reimbursed the \$100 gym fee?**

No. The member will not get reimbursed the \$100 gym fee. In addition, he/she will need to pay the \$10 Home Fitness Program fee in order to receive their Home Fitness Kits.

**7. If a member is participating in the Active&Fit Home Fitness Program and then changes his/her mind and joins a facility, does the member need to return the Home Fitness Kits?**

No. The member may keep the Active&Fit home fitness kits. However, the member will have to pay the \$100 gym fee, and will not get reimbursed the \$10 home fitness fee.

**8. Does the member get a discount on the Gym Program since they already paid a fee for the Home Fitness Program?**

No, the member must pay the \$100 fee in full.

**9. Is this program available outside of the Hawaii service area?**

Yes, members may use their Active&Fit gym membership on the mainland when they travel. The member must call ASHN prior to traveling to register at another gym/facility.

**10. If a member chooses the Active&Fit Home Fitness Program during the enrollment process, how long will it take for the home fitness kits to arrive?**

The kits will be mailed within 30 days of enrollment.

## Kaiser Permanente for Children Plan 2012 Benefits summary

**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 Non-Group Medical and Hospital Service Agreement, benefit schedule, and Riders (collectively known as “Service Agreement”). The Service Agreement is the legally 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
<b>Outpatient services</b>	<b>Primary care and specialty care office visits</b> (office visits are limited to one or more of the following services: exam, history, medical decision making) †  <i>Choice of primary care providers and access to specialty care:</i> <ul style="list-style-type: none"> <li>• Member may choose any primary care physician available to accept Member.</li> <li>• Parents may choose a pediatrician as the primary care physician for their child.</li> <li>• Members do not need a referral or prior authorization for certain specialty care, such as Gynecological care.</li> <li>• The physician may have to get prior authorization for certain services.</li> </ul> <ul style="list-style-type: none"> <li>• Eye examinations for eyeglasses *</li> <li>• Ear examinations to determine the need for hearing correction</li> </ul>	\$7.00 per visit (limited to 12 office visits per calendar year)
	<b>Outpatient surgery and procedures</b>	\$7.00 per visit (in doctor's office)  \$50 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<b>Preventive care services</b> (which protect against disease, promote health, and/or detect disease in its earliest stages before noticeable symptoms develop)  <i>A list of preventive care services provided at no charge is available through the Customer Service Center. This list is subject to change at any time. If you receive any other covered services during a preventive care visit, you will pay the applicable charges for those services.</i>	No charge (non-preventive care services according to member's regular plan benefits)
	<b>Preventive care office visits for:</b> <ul style="list-style-type: none"> <li>• Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, and 5 years)</li> <li>• One preventive care office visit per calendar year for members over 5 years of age †</li> <li>• One gynecological office visit per calendar year for female members †</li> </ul>	No charge
	<b>Routine immunizations</b>	No charge
	<b>Unexpected mass immunizations</b>	50% of applicable charges

- † An office visit related to the provided care counts toward the 12 office visit limit per calendar year. However, an office visit required by state or federal law does not count toward the limit.
- ‡ A hospital stay related to the provided care counts toward the 5 hospital days per calendar year limit. However, a hospital stay required by state or federal law does not count toward the limit.
- ▼ Members must pay their office visit copay for the office visit.
- \* See **Coverage Exclusions** Section
- \*\* See **Coverage Limitations** Section



Section	Benefits	You pay
<b>Outpatient services</b> (continued)	<b>Short-term physical, occupational and speech therapy</b> (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply)	All charges (not covered)
	<b>Dialysis</b> <ul style="list-style-type: none"> <li>Kaiser Permanente physician and facility services for dialysis</li> <li>Equipment, training and medical supplies for home dialysis</li> </ul>	All charges (not covered) All charges (not covered)
	<b>Materials for dressings and casts †</b>	No charge
<b>Hospital inpatient care</b> (for acute care registered bed patients)	<b>Hospital inpatient care</b> includes services such as: ‡ <ul style="list-style-type: none"> <li>Room and board</li> <li>General nursing care and special duty nursing</li> <li>Physicians' services</li> <li>Surgical procedures</li> <li>Respiratory therapy and radiation therapy</li> <li>Anesthesia</li> <li>Medical supplies</li> <li>Use of operating and recovery rooms</li> <li>Intensive care room</li> </ul>	\$100 per day (limited to 5 hospital days per calendar year)
	<b>Short-term physical, occupational and speech therapy ** ‡</b> (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
	<b>Materials for dressings and casts ‡</b>	No charge
<b>Laboratory, imaging, and testing services</b>	<b>Inpatient laboratory services, imaging services, and testing services ‡</b>	No charge
	<b>Outpatient laboratory services, imaging services, and testing services</b>	50% of applicable charges
<b>Transplants</b>	<b>Transplants</b>  <i>The terms and copayments in the applicable benefit sections will apply for services received prior to Health Plan's Transplant Committee identifying the Member as a transplant candidate. Once the Member is identified as a transplant candidate all services related to transplant (including pre-transplant, transplant, and post-transplant related services) are not covered.</i>	All charges (not covered)
<b>Prescribed drugs † ‡</b>	<b>Prescribed drugs that require skilled administration by medical personnel</b> (e.g. cannot be self-administered) which meet all of the following: <ul style="list-style-type: none"> <li>Prescribed by a Kaiser Permanente licensed prescriber,</li> <li>On the Health Plan formulary and used in accordance with formulary criteria, guidelines or restrictions, and</li> <li>Prescription is required by law</li> </ul>	No charge ▼
	<b>Generic diabetes supplies **</b>	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)
	<b>Tobacco cessation drugs and products **</b>	No charge
	<b>Immunizations</b> are described in the outpatient services section	
	<b>Generic oral contraceptive drugs</b> are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section	
	<b>Exclusion:</b> Drugs that are necessary or associated with services that are excluded or not covered	

- † An office visit related to the provided care counts toward the 12 office visit limit per calendar year. However, an office visit required by state or federal law does not count toward the limit.
- ‡ A hospital stay related to the provided care counts toward the 5 hospital days per calendar year limit. However, a hospital stay required by state or federal law does not count toward the limit.
- ▼ Members must pay their office visit copay for the office visit.
- \* See **Coverage Exclusions** Section
- \*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services</b>	<b>Obstetrical (maternity) care</b>	
	<ul style="list-style-type: none"> <li>All maternity care is <u>not covered</u> (such as prenatal visits, delivery/hospital stay, post-partum visits, related labs and diagnostic imaging, etc.)</li> </ul>	All charges (maternity care is not covered)
	<b>Inpatient stay and inpatient care for newborn</b> 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)
	<b>Interrupted pregnancy</b>	
	<ul style="list-style-type: none"> <li>Medically indicated abortions</li> </ul>	\$7.00 per visit (in doctor's office)
		\$50 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<ul style="list-style-type: none"> <li>Elective abortions (including abortion drugs such as RU-486) limited to two per member per lifetime</li> </ul>	\$7.00 per visit (in doctor's office)
		\$50 per day (in a hospital based setting or Ambulatory Surgery Center.)
	<b>Family planning office visits †</b>	\$7.00 per visit
	<b>Generic oral contraceptive drugs **</b> (to prevent unwanted pregnancies) †	\$5.00 per cycle ▼
	<b>Involuntary infertility office visits</b>	All charges (not covered)
	<b>Artificial insemination</b>	All charges (not covered)
	<b>In vitro fertilization *</b>	20% of applicable charges
	<ul style="list-style-type: none"> <li>Limited to one-time only benefit at Kaiser Permanente</li> <li>Limited to female members using spouse's sperm</li> </ul>	
<b>Home health care and hospice care</b>	<b>Home health care</b> , nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	All charges (not covered)
	<b>Hospice care.</b> 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: <ul style="list-style-type: none"> <li>Nursing care (excluding private duty nursing)</li> <li>Medical social services</li> <li>Home health aide services</li> <li>Medical supplies</li> <li>Kaiser Permanente physician services</li> <li>Counseling and coordination of bereavement services</li> <li>Services of volunteers</li> <li>Physical therapy, occupational therapy, or speech language pathology</li> </ul>	All charges (not covered)

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‡ A hospital stay related to the provided care counts toward the 5 hospital days per calendar year limit. However, a hospital stay required by state or federal law does not count toward the limit.

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Skilled nursing care</b>	<p>Up to <b>60 days of prescribed skilled nursing care services in an approved facility</b> (such as a hospital or skilled nursing facility) <b>per benefit period</b>. Covered services include nursing care, room and board, medical social services, medical supplies, and durable medical equipment ordinarily provided by a skilled nursing facility.</p> <p>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.</p> <p><b>Exclusions:</b> Personal comfort items, such as telephone, television and take-home medical supplies.</p>	All charges (not covered)
<b>Emergency services ▲</b> (covered for initial emergency treatment only)	<p>At a facility <u>within</u> the Hawaii service area for covered emergency services</p> <p>At a facility <u>outside</u> the Hawaii service area for covered emergency services</p> <p>Note: Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility.</p> <p>▲ <i>Emergency Services are those medically necessary services available through the emergency department to medically screen, examine and Stabilize the patient for Emergency Medical Conditions. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity that meet the prudent layperson standard and the absence of immediate medical attention will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or place the health of the individual in serious jeopardy. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.</i></p>	<p>\$200 copay per visit</p> <p>\$200 copay per visit</p>
<b>Urgent care services</b>	<p>At a Kaiser (or Kaiser-designated) urgent care center within the Hawaii service area for covered urgent care services †</p> <p>At a non-Kaiser Permanente facility outside the Hawaii service area for covered urgent care services</p> <p>(Coverage for initial urgent care treatment only) ❖</p> <p>❖ <i>"Urgent Care Services" means medically necessary services for a condition that requires prompt medical attention but is not an Emergency Medical Condition. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.</i></p>	<p>\$7.00 per visit</p> <p>20% of applicable charges</p>
<b>Ambulance services</b>	<p>Ambulance Services are those services in which:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Is for the purpose of transporting the member to receive medically necessary acute care.</li> </ul> <p>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.</p>	All charges (not covered)
<b>Blood † ‡</b>	<p>Regardless of replacement, units and processing of units of <b>whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin</b></p> <p>Collection, processing, and storage of <b>autologous blood</b> when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used</p>	<p>No charge</p> <p>No charge</p>

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‡ A hospital stay related to the provided care counts toward the 5 hospital days per calendar year limit. However, a hospital stay required by state or federal law does not count toward the limit.

▼ Members must pay their office visit copay for the office visit.

\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
<b>Mental health services *</b> for serious mental illness	<p>“Serious mental illness” includes schizophrenia, schizo-affective disorder, bipolar types I and II, delusional disorder, major depression, obsessive-compulsive disorder, and dissociative disorder.</p> <p>Up to 24 outpatient office visits (combined with mental health for non-serious mental illness and chemical dependency) per calendar year</p> <p>Up to 30 days of hospital inpatient care (combined with mental health for non-serious mental illness and chemical dependency) per calendar year</p>	<p>\$7.00 per visit</p> <p>\$100 per day</p>
<b>Mental health services *</b> for non-serious mental illness	<p><b>Up to 24 outpatient office visits (combined with mental health for serious mental illness and chemical dependency) per calendar year</b></p> <ul style="list-style-type: none"> <li>Psychological testing * as part of diagnostic evaluation, when ordered by a Kaiser Permanente physician or psychologist</li> </ul> <p><b>Additional outpatient office visits</b>  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</p> <p><b>Up to 30 days of hospital care per calendar year (combined with mental health for serious mental illness and chemical dependency)</b>  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.)</p> <ul style="list-style-type: none"> <li>Hospital care  Services of Kaiser Permanente physicians, mental health professionals and other health care professionals, or Kaiser Permanente physician’s visits in specialized facility</li> <li>Specialized facility services <ul style="list-style-type: none"> <li>➤ Non-hospital residential services</li> <li>➤ Partial hospitalization services or day treatment services in a specialized mental health treatment unit or facility approved by Kaiser Permanente Medical Group</li> </ul> </li> </ul>	<p>\$7.00 per visit</p> <p>\$7.00 per visit</p> <p>\$7.00 per visit</p> <p>\$100 per day</p> <p>\$100 per day</p> <p>\$7.00 per visit</p>
<b>Chemical dependency services **</b>	<p>Up to 24 outpatient office visits (combined with mental health for serious mental illness and mental health for non-serious mental illness) per calendar year</p> <p>Up to 30 days of hospital inpatient care (combined with mental health for serious mental illness and mental health for non-serious mental illness) per calendar year</p> <p>Residential chemical dependency services</p>	<p>\$7.00 per visit</p> <p>\$100 per day</p> <p>All charges (not covered)</p>
<b>Internal prosthetics, devices, and aids † ‡</b>	<p><b>Implanted internal prosthetics</b> (such as pacemakers and hip joints), <b>and internally implanted devices and aids</b> (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</p> <p>Fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss</p> <p><b>Internal prosthetics</b> are those which meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>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,</li> <li>Are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA),</li> </ul>	<p>No charge</p> <p>No charge</p>

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‡ A hospital stay related to the provided care counts toward the 5 hospital days per calendar year limit. However, a hospital stay required by state or federal law does not count toward the limit.

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\* See **Coverage Exclusions** Section

\*\* See **Coverage Limitations** Section

Section	Benefits	You pay
	<ul style="list-style-type: none"> <li>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</li> <li>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.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>All implanted internal prosthetics and devices and internally implanted aids related to an excluded or non-covered service/benefit</li> <li>Prosthetics, devices, and aids related to sexual dysfunction</li> </ul> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>	
<b>Diabetes and home phototherapy equipment</b>	<p><b>Diabetes equipment</b> (limited to blood glucose monitors 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</p> <p><b>Home phototherapy equipment for newborns</b> 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</p> <p><b>Diabetes and home phototherapy equipment</b> is that equipment and supplies necessary to operate the equipment which:</p> <ul style="list-style-type: none"> <li>Is intended for repeated use,</li> <li>Is primarily and customarily used to serve a medical purpose,</li> <li>Is appropriate for use in the home,</li> <li>Is generally not useful to a person in the absence of illness or injury,</li> <li>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,</li> <li>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</li> <li>Is on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>Comfort and convenience equipment, and devices not medical in nature.</li> <li>Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages.</li> <li>Repair, adjustment or replacement due to misuse or loss.</li> <li>Experimental or research equipment.</li> </ul> <p><b>Limitations:</b></p> <ul style="list-style-type: none"> <li>If rented or loaned from Health Plan, the Member must return any diabetes or home phototherapy 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.</li> <li>Coverage is limited to the standard item of diabetes or home phototherapy equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.</li> </ul>	<p>50% of applicable charges</p> <p>No charge</p>

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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
Supplemental charges maximum	There is no supplemental charges maximum for this KP for Children plan.	

- † An office visit related to the provided care counts toward the 12 office visit limit per calendar year. However, an office visit required by state or federal law does not count toward the limit.
- ‡ A hospital stay related to the provided care counts toward the 5 hospital days per calendar year limit. However, a hospital stay required by state or federal law does not count toward the limit.
- ▼ Members must pay their office visit copay for the office visit.
- \* See **Coverage Exclusions** Section
- \*\* See **Coverage Limitations** Section

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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.)
- **Ambulance services**. Including ground or air ambulance services received within or outside the Service Area.
- **Artificial aids, corrective aids and corrective appliances** such as external prosthetics, braces, orthopedic aids, orthotics, hearing aids, corrective lenses and eyeglasses. (The external prosthetic devices and braces portion of this exclusion may not apply if you have an External Prosthetic Devices and Braces Rider. The hearing aids portion of this exclusion may not apply if you have a Hearing Aid Rider. The eyeglasses and contact lens portion of this exclusion may not apply if you have an Optical Rider.)
- **Artificial insemination**.
- **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, including treatment for complications resulting from cosmetic services. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery, incident to a covered mastectomy, or cosmetic service provided by a Physician in a Health Plan facility 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.)
- **Dialysis**. Dialysis for acute renal failure and chronic renal disease.
- **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 blood glucose monitors 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 vision therapy, including orthoptics, visual training and **eye exercises**.
- **Eye surgery** solely for the purpose of correcting refractive defects of the eye, such as Radial Keratotomy (RK), and Photo-refractive keratectomy (PRK).
- **Routine foot care**, unless medically necessary.
- **Health education**: specialized health promotion classes and support groups (such as the bariatric surgery program).
- **Homemaker Services**.
- **Home health care**. Services that are medically necessary health services that (1) can be safely and effectively provided in a Member's home by health care personnel and (2) are prescribed or directed by the Medical Group Home Health Committee.
- **Hospice care**. Care for Members who have been certified by a Physician as having a terminal illness with a life expectancy of six months or less.
- **Involuntary infertility 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 in vitro fertilization, such as artificial insemination, 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.
- **Residential chemical dependency.**
- **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.
- 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.
- Services for injuries or illness caused or alleged to be caused by **third parties or in motor vehicle accidents**.
- **Transplant services.**
- **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.**
- **Skilled nursing care.** Care services within the limitations of the equipment and staff of a **skilled nursing facility**.

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## \*\* 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 **generic oral contraceptive drugs** only when the prescription drugs meet all of the following criteria: 1) prescribed by a licensed Prescriber, 2) available of the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions, 3) the drug is one for which a prescription is required by law, and 4) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc. The copayment is either per 30-consecutive-day supply or per cycle. Only generic oral contraceptive drugs are covered, even if Prescriber deems a brand-name drug necessary.



- **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.
- Up to a 30-consecutive-day supply of generic **diabetes supplies** is provided (as described under the **prescribed drugs** section) if all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate. Only generic diabetes supplies are covered, even if a Prescriber deems a brand-name drug necessary.
- 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.
- Up to a 30-consecutive-day supply of **tobacco cessation drugs and products** is provided when all of the following criteria are met: 1) available on the Health Plan formulary's Tobacco Cessation list of approved drugs and products, including over-the-counter drugs and products, and in accordance with formulary criteria, guidelines, or restrictions, 2) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate, and 3) Member meets Health Plan-approved program-defined requirements for smoking cessation classes or counseling (tobacco cessation classes and counseling sessions are provided at no charge).
- **Tuberculin skin test** is limited to one per calendar year, unless medically necessary.
- **Office visits limited to 12 per calendar year**, other than state or federal law required.
- **Hospital days limited to 5 per calendar year**, other than state or federal law required.

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### 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
<b>Generic Antibiotic Drug benefit 5 for KP for Children Plan</b>	<p><b>For each prescription of generic antibiotic drugs, when the quantity does not exceed:</b></p> <ul style="list-style-type: none"> <li>• a 30–consecutive-day supply of a prescribed drug, or</li> <li>• an amount as determined by the formulary.</li> </ul> <p><b>Self-administered generic antibiotic drugs</b> are covered only when all of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate,</li> <li>• on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions,</li> <li>• the drug is one for which a prescription is required by law,</li> <li>• 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</li> <li>• drug does not require administration by nor observation by medical personnel.</li> </ul> <p><b>Generic diabetes supplies and tobacco cessation drugs and products</b> are described in the prescribed drugs section</p> <p><b>Generic oral contraceptive drugs</b> are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section</p> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Drugs related to obstetrical (maternity) care.</li> <li>• Self-administered drugs, except when required by law or listed as covered in the above sections.</li> <li>• 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. This exclusion does not apply to tobacco cessation drugs and products as described in the prescribed drugs section.</li> <li>• 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.</li> <li>• Drugs obtained from a non-Kaiser Permanente pharmacy.</li> <li>• Non-prescription vitamins.</li> <li>• Drugs when used primarily for cosmetic purposes.</li> <li>• Medical supplies such as dressings and antiseptics.</li> <li>• Reusable devices such as blood glucose monitors and lancet cartridges.</li> <li>• Diabetes supplies such as blood glucose test strips, lancets, syringes and needles.</li> <li>• Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate.</li> <li>• Brand-name drugs requested by a Member when there is a generic equivalent.</li> <li>• Prescribed drugs that are necessary for or associated with excluded or non-covered services.</li> <li>• Drugs related to sexual dysfunction.</li> <li>• Drugs to shorten the duration of the common cold.</li> <li>• Drugs related to enhancing athletic performance (such as weight training and body building).</li> <li>• Any packaging other than the dispensing pharmacy's standard packaging.</li> <li>• Immunizations, including travel immunizations.</li> <li>• Contraceptive drugs and devices (to prevent unwanted pregnancies).</li> <li>• Abortion drugs (such as RU-486).</li> <li>• Replacement of lost, stolen or damaged drugs.</li> </ul>	\$5 per prescription

## Questions and answers about the generic antibiotic drug benefit for the KP for Children 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 \$5 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 generic antibiotic drug rider. However drugs on our formulary may not be automatically covered under your prescription drug rider depending on which plan you've selected.

Kaiser Permanente pharmacies may substitute a chemical or generic equivalent for a brand-name drug unless this is prohibited by your Kaiser Permanente physician.

### 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. Unless otherwise directed by Kaiser Permanente, refills may be allowed when 75% of the current prescription supply is taken/administered according to prescriber's directions.

### 6. *How do I receive prescriptions by mail?*

Save time and money on refills! If you have prescription drug coverage, you can get a 90-day supply of qualified prescription drugs covered under your drug rider for the price of 60 by using our convenient mail order service\*. And we pay the postage!

You can order your refills at your convenience, 24/7, using one of the methods below.

- For the quickest turnaround time, order online at [kp.org](http://kp.org).
- Order via our automated prescription refill service by calling 432-7979 (Oahu) or 1-888-867-2118 (Neighbor Islands). You'll have the following options:
  - To check your order status, press 1.
  - To order refills, press 2. You will be asked to enter your medical record number and prescription number. Then you'll have the option of receiving your refills via mail order (by pressing 1) or picking up your refills at one of our locations (by pressing 2)
  - To listen to detailed instructions, press 3.
- Order using our mail-order envelope, available at all Kaiser Permanente clinic locations.
- Order via our Pharmacy Refill Center at (808) 432-5510 (Oahu), or toll free 1-866-250-1805 (Neighbor Islands), Monday to Friday, 8:30 a.m. to 5 p.m. TTY users may call 1-877-447-5990.

So the next time you've used two-thirds of your existing supply of prescription medications, try using one of these convenient options.

If you must pick up your prescriptions at a clinic pharmacy, refillable prescriptions are usually ready for pickup at the designated pharmacy in one business day. Prescriptions requiring a physician's approval are usually ready in two business days. Call the pharmacy or Kaiser Permanente Hawaii's automated prescription refill line in advance to make sure that your prescription is ready. Orders not picked up within one week are returned to stock.

\*We are not licensed to mail medications out of state. There are restrictions for delivery of certain medications and supplies, including but not limited to controlled medications, injections, medications affected by temperature, and medications excluded by Kaiser Permanente's Pharmacy & Therapeutic Committee.

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Kaiser Permanente for Individuals and Families

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Visit **buykp.org/apply**  
or call **1-800-494-5314**

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