

Kaiser Foundation Health Plan, Inc.
A NONPROFIT HEALTH PLAN - HAWAII REGION

**2016 Summary of Important Changes for Contract Renewals for the
Kaiser Permanente Group Plan**
(These changes are subject to regulatory approval)

This summary does not apply to Added Choice out-of-network coverage, Kaiser Permanente for Individuals and Families, Federal, State, Medicaid members or Medicare members.

This summary does not fully describe your coverage. For details on your coverage, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders if any (collectively known as "Service Agreement"). The Service Agreement is the legally binding document between Health Plan and its members. In the event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control.

For specific questions about benefits, you may call our Customer Service Center at 1-800-966-5955.

Your employer may have purchased benefits (referred to as "riders") that override some of these changes. However, riders are not available for some of the changes described below.

Under the Patient Protection and Affordable Care Act (PPACA), your coverage may be considered a "grandfathered plan." Some of the benefit changes below may not be applicable to a grandfathered plan.

CONTRACT CHANGES: (that apply to all group plans)

These changes become effective on your employer's contract renewal date, unless specified otherwise below.

1. **Benefits covered with a single copay or coinsurance.** Services provided as part of the hospital, observation, outpatient surgery or procedure (performed in an ambulatory surgery center or outpatient hospital setting), skilled nursing facility, dialysis, radiation therapy, and emergency room benefit categories will be covered under a single copay or coinsurance. (However, the complex imaging copay or coinsurance will continue to apply if such services are received during an emergency room visit.)
2. **In vitro fertilization.** In vitro fertilization will be covered for unmarried women and for women using a non-spousal sperm donor. Current benefit copays, coinsurance, limitations and exclusions still apply.
3. **State mandates.** Coverage will be added for orthodontic services for treatment of orofacial anomalies due to birth defects. Coverage is also being added for diagnosis and treatment of autism. (For both benefits, age and dollar limits in accord with state law apply.)

CONTRACT LANGUAGE CLARIFICATIONS (that apply to all group plans)

These clarifications are effective immediately, unless otherwise specified below.

1. **Language clarifications.** Language clarifications have been made to the Service Agreement to comply with the PPACA.

PLAN SPECIFIC COST SHARE CHANGES

These changes become effective on your employer's contract renewal date, unless specified otherwise below.

1. **KP Group \$25/\$150 (50% Lab Imaging and Testing) Plan**
 - Supplemental charges maximum will be \$3,000 per member/\$9,000 for family of 3 or more members (was \$2,500/\$7,500).
2. **KP Group \$20/20% Plan (formerly called KP Group \$12/20% Plan)**
 - Primary office visit will be \$20 per visit (was \$12 per visit). Specialist office visit will be \$30 per visit (was \$20 per visit).
3. **KP Platinum - \$20 Plan**
 - Specialty drug will be \$75 per prescription (was \$45 per prescription).

4. KP Platinum I - \$15 Plan

- Outpatient specialty laboratory/imaging will be 10% (was \$20 per day). Brand drug will be \$45 per prescription (was \$35 per prescription) and specialty drug will be \$75 per prescription (was \$35 per prescription).

5. KP Gold - \$15 Plan.

- There will be a separate limit on supplemental charges for pharmacy-dispensed drugs in the amount of \$4,650 per member/\$9,300 for family of 2 or more members. (Previously, pharmacy-dispensed drugs were counted toward the medical supplemental charges maximum.)
- Prescription drug deductible for specialty drug prescriptions will be \$400 per member/\$800 for family of 2 or more members (was \$250/\$500).

6. KP Gold - \$17 Plan (formerly called KP Gold - \$12 Plan)

- Medical deductible will be \$50 per member/\$100 for family of 2 or more members (was \$0/\$0).
- Primary office visit will be \$17 per visit (was \$12 per visit).
- Specialist office visit will be \$25 per visit (was \$20 per visit).
- Hospital inpatient will be 20% *after deductible*. (Previously this benefit was not subject to the deductible)
- *Observation will be 20% after deductible*. (Previously this benefit was not subject to the deductible)
- Outpatient specialty laboratory/imaging will be 20% *after deductible*. (Previously this benefit was not subject to the deductible)
- *Outpatient surgery/procedures in an ambulatory surgery center or outpatient hospital based setting will be 20% after deductible*. (Previously this benefit was not subject to the deductible)
- Generic maintenance drug will be \$10 per prescription (was \$5 per prescription) and other generic drug will be \$20 per prescription (was \$15 per prescription).
- Emergency services (in/out of area) will be 20% *after deductible*. (Previously this benefit was not subject to the deductible)
- *Skilled nursing care (up to 120 days per accumulation period) will be 20% after deductible*. (Previously this benefit was not subject to the deductible).

7. KP Silver - \$30 Plan

- Medical deductible will be \$1,200 per member/\$2,400 for family of 2 or more members (was \$1,000/\$2,000).
- Hospital inpatient will be \$750/day (was \$500/day).
- Observation will be \$750/day (was \$500/day).
- Generic maintenance drug will be \$10 per prescription (was \$5 per prescription), and other generic drug will be \$20 (was \$15 per prescription).



**2016 Features of your Kaiser Permanente
group plan**

Benefit	Member Pays
Deductible	None
Annual supplemental charges maximum per calendar year	\$2,500 / \$7,500
Preventive services	
Well-child office visits	No charge
Routine immunizations	No charge
One Preventive care office visit per calendar year (age 2 and older)	No charge
One gynecological office visit per calendar year (for female members)	No charge
Outpatient services	
Office visits	\$15 per visit
Surgery and procedures	\$15 per visit
Routine obstetrical (maternity) care	No charge
FDA-approved contraceptive drugs and devices	50% of applicable charges
Inpatient services	
Hospital room and board, doctors' medical and surgical services, and anesthesia services	\$50 per day
Laboratory, imaging, and testing services	
Inpatient lab, imaging, and testing	Included in hospital inpatient copay
Outpatient lab, imaging, and testing	No charge
Mental health services	
Outpatient office visits	\$15 per visit
Hospital inpatient care	\$50 per day
Day treatment or partial hospitalization services	\$15 per visit
Non-hospital residential services	\$50 per day
Chemical dependency services	
Outpatient office visits	\$15 per visit
Hospital inpatient care	\$50 per day
Day treatment or partial hospitalization services	\$15 per visit
Non-hospital residential services	\$50 per day
Emergency services (for initial treatment only—copay is waived if admitted)	
Within the Hawaii service area	\$50 per visit
Outside the Hawaii service area	20% of applicable charges
Ambulance services	No charge
Diabetes equipment and internal prosthetics, devices, and aids	
Diabetes equipment	50% of applicable charges
Internal prosthetics, devices, and aids	No charge
External prosthesis / durable medical equipment (with additional hearing aid allowance; see rider for details)	No charge
All care and services must be coordinated by a Kaiser Permanente physician.	

This is only a summary. It does not fully describe your benefit coverage. For more details on your benefit coverage, exclusions, limitations, and plan terms, or for information, please refer to the attached, detailed benefit summary, to your employer, to *Our physicians and locations* directory for practitioner and provider availability, and to your *Member handbook*. This document is meant to be reviewed in conjunction with the attached, detailed benefit summary.

Benefit	Member Pays
Additional services	
Prescription drug 10 **Applies towards the annual supplemental charges maximum per calendar year	\$10 per prescription
Prescription drug mail-order incentive	Two drug copayments for a 90-consecutive-day supply

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

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

* See **Coverage Exclusions**

** See **Coverage Limitations**

**Kaiser Permanente Group Plan
2016 Benefits summary**

This is only a summary, and is not the legally binding document between the Health Plan and its members. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, 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. Senior Advantage members must refer to their Kaiser Permanente Senior Advantage Evidence of Coverage for a description of their benefits. Medicare Cost members must refer to their Kaiser Permanente Medicare Cost Evidence of Coverage for a description of their benefits.

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.

Your employer may have purchased benefits (referred to as "riders") that override some of the benefits listed below. Riders, if any, are described after the Exclusions and Limitations section.

Section	Benefits	You pay
Outpatient Services	Primary care office visits**	\$15 per visit
	Specialty care office visits**	\$15 per visit
	Outpatient surgery and procedures	
	• provided in medical office	\$15 per visit
	• provided in ambulatory surgery center (ASC) or hospital-based setting	\$15 per visit
	*Physical, occupational, and speech therapy	
	• includes short-term therapy **	\$15 per visit
	Dialysis	
	• Kaiser Permanente physician and facility services for dialysis	10% of applicable charges
	• Equipment, training and medical supplies for home dialysis	No charge
	Materials for dressings and casts	No charge [†]
Hospital inpatient care	Hospital inpatient care**	\$50 per day
	*Physical, occupational and speech therapy	
	• includes short-term therapy **	Included in the above hospital inpatient care copay
	Materials for dressings and casts	Included in the above hospital inpatient care copay
	Inpatient lab, imaging, and testing	Included in the above hospital inpatient care copay
Outpatient laboratory, imaging, and testing services	Laboratory services**	No charge
	Imaging services **	No charge
	Testing services **	No charge
Outpatient radiation therapy	Radiation therapy, including radium therapy and radioactive isotope therapy	\$20 per visit

[†] When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

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

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You pay
*Transplants	Transplants , including kidney, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel, and small bowel-liver transplants *	See applicable benefit sections (e.g. - office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.)
Preventive screening services	<p>Preventive screening services which meet Kaiser Permanente Prevention Committee's average risk guidelines are limited to the services listed below:</p> <ul style="list-style-type: none"> • Anemia and lead screening for children • Colorectal cancer screening • Chlamydia detection • Fecal occult blood test • Lipid evaluation • Newborn metabolic screening • Cervical cancer screening • Screening mammography • Osteoporosis screening <p>Preventive care office visits</p> <ul style="list-style-type: none"> • Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months and 18 months) • One preventive care office visit per calendar year for members 2 years of age and over • One gynecological office visit per calendar year for female members 	<p>No charge; member pays \$15 for office visit if applicable</p> <p>No charge</p>
Prescribed drugs	<p>Prescribed drugs that require skilled administration by medical personnel (e.g. cannot be self-administered)**</p> <p>FDA-approved contraceptive drugs and devices available on Kaiser Permanente's formulary **</p> <p>All other FDA-approved contraceptive drugs and devices ** (a minimum price as determined by Pharmacy Administration may apply) ▼</p> <p>Routine immunizations</p> <p>Unexpected mass immunizations</p> <p>Diabetes supplies **</p> <p>Tobacco cessation drugs and products **</p>	<p>No charge ▼†</p> <p>No charge</p> <p>50% of applicable charges</p> <p>No charge</p> <p>50% of applicable charges</p> <p>50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)</p> <p>No charge</p>
<i>Your group may have purchased drug coverage for self-administered drugs under a separate rider. If so, it will be listed on the attached pages.</i>		

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

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

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You pay
Obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services	Routine obstetrical (maternity) care**	
	<ul style="list-style-type: none"> • Routine prenatal visits • Routine postpartum visit • Delivery/hospital stay (uncomplicated) 	No charge No charge \$50 per day
	Inpatient stay and inpatient care for newborn during or after mother's hospital stay (assuming newborn is timely enrolled on Kaiser Permanente subscriber's plan)	Hospital inpatient care benefits apply (see hospital inpatient care section)
	Interrupted pregnancy**	
	<ul style="list-style-type: none"> • Medically indicated abortions • Elective abortions (including abortion drugs such as RU-486) limited to two per member per lifetime 	\$15 per visit [†] \$15 per visit [†]
	Family planning office visits	\$15 per visit, except Women's Health benefits required by Health Care Reform at no charge
	Involuntary infertility office visits Voluntary sterilizations for female members** *In vitro fertilization** *Artificial insemination*	\$15 per visit No charge 20% of applicable charges \$15 per visit
Emergency services**	At a facility within the Hawaii service area for covered emergency services	\$50 per visit
	At a facility outside the Hawaii service area for covered emergency services	20% of applicable charges
Urgent care services**	At a Kaiser (or Kaiser-designated) urgent care center <u>within</u> the Hawaii service area for covered urgent care services	\$15 per visit
	At a non-Kaiser Permanente facility outside the Hawaii service area for covered urgent care services	20% of applicable charges
Ambulance services	Ambulance Services**	No charge
Blood	Blood and blood processing**	No charge [†]
Mental health services**	Mental health outpatient services, including office visits, day treatment and partial hospitalization services	Applicable office visit copay
	Mental health hospital inpatient care, including non-hospital residential services	\$50 per day
Chemical dependency services**	Chemical dependency outpatient services, including office visits, day treatment and partial hospitalization services	Applicable office visit copay
	Chemical dependency hospital inpatient care, including non-hospital residential services	\$50 per day
Home health care and hospice care	Home health care , nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	No charge (office visit copay applies for physician house calls)
	Hospice care**	No charge (office visit copay applies for physician visits)
Skilled nursing care rider - 120 days	Prescribed skilled nursing care** , per Accumulation Period	No charge for up to 120 days

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

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

* See Coverage Exclusions

** See Coverage Limitations

Section	Benefits	You pay
Internal prosthetics, devices, and aids **	Implanted internal prosthetics , including: <ul style="list-style-type: none"> Fitting and adjustment of these devices, including repairs and replacements other than those due to misuse and loss 	No charge †
Durable medical equipment / External prosthetic devices and braces **	Durable medical equipment , including: <ul style="list-style-type: none"> Oxygen for use in conjunction with prescribed durable medical equipment Repair, replacement and adjustment of durable medical equipment, other than due to misuse or loss Diabetes equipment Home phototherapy equipment for newborns Breast feeding pump External prosthetic devices and braces , including speech generating devices and voice synthesizers	No charge 50% of applicable charges No charge No charge No charge
Hearing aids**	Hearing aids , provided once every three years for each impaired ear <ul style="list-style-type: none"> Hearing test (audiogram) to determine hearing capabilities 	60% of applicable charges for standard hearing aids, per ear, every 3 years \$15 per visit
Dependent coverage**	Dependent (biological, step or adopted) children of the Subscriber (or the Subscriber's spouse) are eligible up to the child's 26 th birthday.	
Supplemental charges maximum**	Your out-of-pocket expenses for covered Basic Health Services are capped each year by a supplemental charges maximum .	\$2,500 per member, \$7,500 per family unit for calendar year
Grandfathered Coverage	Health Plan believes coverage under this Service Agreement is a "grandfathered health plan" under the Patient Protection and Affordability Care Act. As permitted by the Patient Protection and Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Questions regarding grandfathered health plans may be directed to the Customer Service Center.	

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

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

* See **Coverage Exclusions**

** See **Coverage Limitations**

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:

- **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 orthopedic aids, corrective lenses and eyeglasses. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, external prosthetic devices, braces, and hearing aids may be covered benefits). Corrective lenses and eyeglasses may be covered for certain medical conditions, if all essential health benefits are required to be covered. Pediatric vision care services and devices may also be covered as an essential health benefit. (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**, including pediatric oral care, such as dental x-rays, dental implants, dental appliances, or orthodontia and Services relating to Craniomandibular Pain Syndrome. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, Services relating to temporomandibular joint dysfunction (TMJ) may be covered). (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 as described in the above benefit sections (e.g., diabetes blood glucose monitors and external insulin pumps are covered). If your plan is required to cover all essential health benefits, then this exclusion does not apply (for example, durable medical equipment may be a covered benefit). (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 and vision therapy, including orthoptics, visual training and **eye exercises**. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, habilitative services and pediatric vision care services may be covered). (Eye exams for contact lens may be partially covered if you have an Optical Rider.)
- **Eye surgery** solely for the purpose of correcting refractive defects of the eye, such as Radial keratotomy (RK), and Photo-refractive keratectomy (PRK). If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, vision procedures for certain medical conditions may be covered).

- **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.
- **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; applied behavioral analysis services; routine vision services.
- **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 practitioner's services for treatment of sexual dysfunction.
- Personal comfort items, such as telephone, television, and take-home medical supplies, for covered **skilled nursing care.**
- Services, drugs, prosthetics, devices or surgery related to **gender re-assignment** surgery, including surgery and prosthetics.
- **Take home supplies** for home use, such as bandages, gauze, tape, antiseptics, ace type bandages, drug and ostomy supplies, catheters and tubing.
- The following costs and Services for **transplants:**
 - Non-human and artificial organs and their transplantation.
 - Bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tissue tumors, except for germ cell tumors and neuroblastoma in children.
- Services for injuries or illness caused or alleged to be caused by **third parties or in motor vehicle accidents.**
- **Transportation** (other than covered ambulance services), **lodging, and living expenses.**
- **Travel immunizations.**
- **Services for which coverage has been exhausted, Services not listed as covered, or excluded Services.**

****Coverage limitations**

Benefits and Services are subject to the following limitations:

- Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.
- Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when physicians believe no professionally acceptable alternative to treatment exists. Coverage will cease at the point the member stops following the recommended treatment.
- **Ambulance services** are those services which: 1) 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 2) is for the purpose of transporting the member to receive medically necessary acute care. In addition, air ambulance must be for the purpose of transporting the Member to the nearest medical facility designated by Health Plan for receipt of medically necessary acute care, and the member's condition must require the services of an air ambulance for safe transport.
- Coverage of **blood and blood processing** includes (regardless of replacement, units and processing of units) whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin. Coverage also includes collection, processing, and storage of autologous blood when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used.
- **Chemical dependency services** include coverage in a specialized alcohol or chemical dependence treatment unit or facility approved by Kaiser Permanente Medical Group. Specialized alcohol or chemical dependence treatment services include day treatment or partial hospitalization services and non-hospital residential services.
- Members are covered for **contraceptive drugs and devices** (to prevent unwanted pregnancies) only when all of the following criteria are met: 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.
- When applicable, the **deductible** is the amount that members must pay for certain services before Health Plan will cover those services. Services that are subject to the deductible are noted in the "You Pay" column of this benefit summary (for example, if "after deductible" is noted in the "You Pay" column after the copayment, then members or family units must meet the deductible before the noted copayment will be effective). This deductible is separate from any other benefit-specific deductible that may be described herein. For example if prescription drugs are subject to a drug deductible, payments toward that drug deductible do not count toward this deductible. Consequently, payments toward this deductible do not count toward any other benefit-specific deductible (such as a drug deductible). Services that are subject to this deductible are: 1) outpatient surgery or procedures provided in an ambulatory surgery center (ASC) or other hospital-based setting, 2) hospital inpatient care, 3) specialty laboratory services, 4) specialty imaging services, 5) skilled nursing care, and 6) emergency services.
- 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.
- **Emergency services** are covered for initial emergency treatment only. Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility. Emergency Services are those medically necessary services 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.
- When applicable, **essential health benefits** are provided to the extent required by law and include ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services to the extent required by HHS and EHB-benchmark plan. Pediatric oral care services are covered under this Service Agreement only if a separate Dental Rider is attached (covered services are described within any applicable Dental Rider). A complete list of essential health benefits is available through the customer service center. Essential health benefits are provided upon payment of the copayments listed under the appropriate benefit sections (e.g. . office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.).

- When covered under the preventive care services section, the following types of **female sterilizations** and related items and services are provided: 1) sterilization surgery for women: Trans-abdominal Surgical Sterilization/Surgical Implant; 2) sterilization implant for women: Trans-cervical Surgical Sterilization Implant; 3) pre and post operative visits associated with female sterilization procedures; and 4) Hysterosalpingogram test following sterilization implant procedure.
- Coverage of **hospice care** is 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: 1) nursing care (excluding private duty nursing), 2) medical social services, 3) home health aide services, 4) medical supplies, 5) physician services, 6) counseling and coordination of bereavement services, 7) services of volunteers, and 8) physical therapy, occupational therapy, or speech language pathology.
- **Hospital inpatient care** (for acute care registered bed patients) includes services such as: 1) room and board, 2) general nursing care and special duty nursing, 3) physicians. services, 4) surgical procedures, 5) respiratory therapy and radiation therapy, 6) anesthesia, 7) medical supplies, 8) use of operating and recovery rooms, 9) intensive care room, 10) laboratory services, 11) imaging services, 12) testing services, 13) radiation therapy, 14) physical therapy, 15) occupational therapy, 16) speech therapy, 17) administered drugs, 18) internal prosthetics and devices, 19) blood, 20) durable medical equipment ordinarily furnished by a Hospital, and 21) external prosthetic devices and braces.
- Specialty **imaging services** are services such as CT, interventional radiology, MRI, nuclear medicine, and ultrasound. General radiology includes services such as x-rays and diagnostic mammography.
- Coverage of **in vitro fertilization** is limited to a one-time only benefit at Kaiser Permanente. Please see Coverage Exclusions above for services and items not covered.
- **Internal prosthetics, devices, and aids** (such as pacemakers, hip joints, surgical mesh, stents, bone cement, bolts, screws, and rods) must be prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan. Internal prosthetics, devices, and aids are **those which meet all of the following**: 1) 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, 2) are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA), 3) 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 4) 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. Fitting and adjustment of these devices, including repairs and replacement other than due to misuse or loss, is included in coverage. The following are excluded from coverage: a) all implanted internal prosthetics and devices and internally implanted aids related to an excluded or non covered service/benefit, and b) Prosthetics, devices, and aids related to sexual dysfunction. 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.
- The following **interrupted pregnancies** are included: 1) medically indicated abortions, and 2) elective abortions (including abortion drugs such as RU-486). Elective abortions are limited to two per member per lifetime.
- Specialty **laboratory services** include tissue samples, cell studies, chromosome studies, and testing for genetic diseases. All other laboratory services are considered basic lab services.
- **Mental health services** include coverage in a specialized mental health treatment unit or facility approved by Kaiser Permanente Medical Group. Specialized mental health treatment services include day treatment or partial hospitalization services and non-hospital residential services.
- **Office visits** are limited to one or more of the following services: exam, history, and/or medical decision making. Office visits also include: 1) eye examinations for eyeglasses (see also Coverage Exclusions for more information on eye examinations), and 2) ear examinations to determine the need for hearing correction. Members. choice of primary care providers and access to specialty care allow for the following: 1) Member may choose any primary care physician available to accept Member, 2) parents may choose a pediatrician as the primary care physician for their child, 3) Members do not need a referral or prior authorization for certain specialty care, such as obstetrical or gynecological care, and 4) the physician may have to get prior authorization for certain services.
- Short-term **physical, occupational and speech therapy** (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply) services means medical services provided for those conditions which meet all of the following criteria: 1) the therapy is ordered by a Physician under an individual treatment plan; 2) in the judgment of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy; 3) the therapy is provided by or under the supervision of a Physician-designated licensed physical, speech, or occupational therapist, as appropriate.; and 4) 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: a) neurological and/or musculoskeletal function is the level of the average healthy person of the same age, b) further significant functional gain is unlikely, or c) 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.

- **Prescribed drugs that require skilled administration by medical personnel** must meet all of the following: 1) prescribed by a Kaiser Permanente licensed prescriber, 2) on the Health Plan formulary and used in accordance with formulary guidelines or restrictions, and 3) prescription is required by law.
- In accordance with **routine obstetrical (maternity) care**, if member is discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), the member's Kaiser Permanente physician may order a follow-up visit for the member and newborn to take place within 48 hours after discharge.
- Covered **skilled nursing care** in an approved facility (such as a hospital or skilled nursing facility) per Benefit Period, include the following services: 1) nursing care, 2) room and board, 3) medical social services, 4) medical supplies, and 5) 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.
- Your out-of-pocket expenses for covered Basic Health Services are capped each year by a **supplemental charges maximum**. Payments toward any applicable deductible count toward the limit on supplemental charges. You may retain your receipts for these Supplemental Charges and when that maximum amount has been incurred and/or paid, present these receipts to our Business Office at Moanalua Medical Center, Honolulu, Waipio, or Wailuku Clinics or to the cashier at other clinics. After verification that the Supplemental Charges Maximum has been incurred and/or paid, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to ensure no additional Supplemental Charges are billed or collected for the remainder of the calendar year in which the medical services were received. All payments are credited toward the calendar year in which the medical services were received.
- Supplemental charges for the following covered Basic Health Services can be applied toward the supplemental charges maximum: ambulance service, artificial insemination, chemical dependency services (including 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), inpatient services (including general nursing care and special duty nursing, physicians' services, surgical procedures, respiratory therapy, anesthesia, medical supplies, use of operating and recovery rooms, intensive care room and related hospital services, special diet, and observation), interrupted pregnancy/abortion, laboratory, mental health services, obstetrical (maternity) care, 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. The following services are not Basic Health Services and charges for these services/items are not applicable towards the Supplemental Charges Maximum: all services for which coverage has been exhausted, all excluded or non covered benefits, 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, office visits for services which are not Basic Health Services, orthopedic devices, radioactive materials, self administered/outpatient prescription drugs, skilled nursing care, take-home supplies, and travel immunizations.
- Up to a 30-consecutive-day supply of **tobacco cessation drugs and products** is provided when all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) 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, 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, and 4) 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.
- **Urgent care services** are covered for initial urgent care treatment only. "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.

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

Kaiser Permanente has the right to recover the cost of care for a member's injury or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the member by an insurance company, individual or other third party. Kaiser Permanente has the right to recover the cost of care for Surrogacy Health Services. Surrogacy Health Services are Services the Member receives related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement. The Member must reimburse Kaiser Permanente for the costs of Surrogacy Health Services, out of the compensation the Member or the Member's payee are entitled to receive under the Surrogacy Arrangement.

	Benefits	You pay
Drug rider 10	<p>For each prescription, when the quantity does not exceed:</p> <ul style="list-style-type: none"> • a 30-consecutive-day supply of a prescribed drug, or • an amount as determined by the formulary. <p>Self-administered drugs are covered only when all of the following criteria are met:</p> <ul style="list-style-type: none"> • prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate, • on the Kaiser Permanente Hawaii Drug Formulary. Senior Advantage members with Medicare Part D are entitled to drugs on the Kaiser Permanente Hawaii Drug Formulary and Kaiser Permanente Hawaii Medicare Drug Formulary. Drugs must be used in accordance with formulary criteria, guidelines, or restrictions, • the drug is one for which a prescription is required by law, • obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc., or pharmacies we designate, and • drug does not require administration by nor observation by medical personnel.. 	\$10 per prescription
	<p>Insulin</p> <p>Self-administered prescription drugs, including drugs for the treatment of cancer, are provided in accordance with state and federal law.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • 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. • Drugs and their associated dosage strengths and forms in the same therapeutic category as a non-prescription drug that have the same indication as the non-prescription drug. • Drugs obtained from a non-Kaiser Permanente pharmacy. • Non-prescription vitamins. • Drugs when used primarily for cosmetic purposes. • Medical supplies such as dressings and antiseptics. • Reusable devices such as blood glucose monitors and lancet cartridges. • Diabetes supplies such as blood glucose test strips, lancets, syringes and needles. • Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate. • Brand-name drugs requested by a Member when there is a generic equivalent. • Prescribed drugs that are necessary for or associated with excluded or non-covered services, except for Senior Advantage Members with Medicare Part D. • Drugs related to sexual dysfunction. • Drugs to shorten the duration of the common cold. • Drugs related to enhancing athletic performance (such as weight training and body building). • Any packaging other than the dispensing pharmacy's standard packaging. • Immunizations, including travel immunizations. • Contraceptive drugs and devices (to prevent unwanted pregnancies). • Abortion drugs (such as RU-486). • Replacement of lost, stolen or damaged drugs. 	\$10 per prescription

Questions and answers about the drug rider

1. *How does the drug rider 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 \$10 for a prescription when it does not exceed a 30-consecutive-day supply of a prescribed drug (or an amount as determined by the formulary). Each refill of the same prescription will also be provided at the same charge.
- If you go to a non-Kaiser Permanente pharmacy, you will be responsible for 100% of charges.

2. *Where are Kaiser Permanente pharmacies located?*

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

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

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

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

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

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

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

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

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

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.
- 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.