KAISER PERMANENTE®

Bayada Home Health Care, Inc.
• kp.org

2015 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	$20 per visit
Surgery and procedures	$20 per visit
Routine obstetrical (maternity) care	No charge
FDA-approved contraceptive drugs and devices	Patient Protection & Affordable Care Act (PPACA)-Mandated Drugs/Devices On KP Formulary - No charge All Other Drugs & Devices - 50% of applicable charges
Inpatient services	
Hospital room and board, doctors' medical and surgical services, and anesthesia services	$75 per day
Laboratory, imaging, and testing services	
Inpatient lab, imaging, and testing	Included in hospital inpatient copay
Outpatient lab, imaging, and testing	10% of applicable charges
Mental health services	
Outpatient office visits	$20 per visit
Hospital inpatient care	$75 per day
Day treatment or partial hospitalization services	$20 per visit
Non-hospital residential services	$75 per day
Chemical dependency services	
Outpatient office visits	$20 per visit
Hospital inpatient care	$75 per day
Day treatment or partial hospitalization services	$20 per visit
Non-hospital residential services	$75 per day
Emergency services (for initial treatment only–copay is waived if admitted)	
Within the Hawaii service area	$75 per visit
Outside the Hawaii service area	$75 per visit
Ambulance services	20% of applicable charges
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)	20% of applicable charges
All care and services must be coordinated by a Kaiser Permanente physician.	
Additional services	
3-Tier Prescription drug 5/10/45 **Applies towards the annual supplemental charges maximum per calendar year	Generic Maintenance Drugs: $5 per prescription Other Generic Drugs: $10 per prescription Brand-Name Drugs: $45 per prescription

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
Prescription drug mail-order incentive	Two drug copayments for a 90-consecutive-day supply
Dental services	**Plan pays**
Annual exam (once per calendar year)	100% of Allowed Amount
Bitewing X-rays (once per calendar year	100% of Allowed Amount
Cleaning (twice per calendar year)	100% of Allowed Amount
Restorative	70% of Allowed Amount
Prosthodontics and crowns	50% of Allowed Amount
Chiropractic and acupuncture services (up to 12 visits per calendar year)	$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**

Kaiser Permanente Group Plan
2015 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****	$20 per visit
	Specialty care office visits**	$20 per visit
	Outpatient surgery and procedures	
	• provided in medical office	$20 per visit
	***Physical, occupational, and speech therapy**	
	• includes short-term therapy **	$20 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****	$75 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
Outpatient laboratory, imaging, and testing services	**Laboratory services****	10% of applicable charges
	Imaging services **	10% of applicable charges
	Testing services **	10% of applicable charges
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	**Preventive care services** (which protect against disease, promote health, and/or detect disease in its earliest stages before noticeable symptoms develop) • FDA approved contraceptive drugs and devices** that are available on the Health Plan formulary, as required by the federal Patient Protection and Affordable Care Act (PPACA). Coverage of all other FDA approved contraceptive drugs and devices are described in the Obstetrical care section. • Female sterilizations** • Rental or purchase of breast feeding pump, including any equipment that is required for pump functionality *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.*	No charge; (non-preventive care services according to member's regular plan benefits)
	Preventive care office visits • 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	No charge
Prescribed drugs	**Prescribed drugs that require skilled administration by medical personnel** (e.g. cannot be self-administered)**	
	FDA-approved contraceptive drugs and devices available on Kaiser Permanente's formulary **	No charge
	All other FDA-approved contraceptive drugs and devices ** (a minimum price as determined by Pharmacy Administration may apply) ▼	50% of applicable charges
	Routine immunizations	No charge
	Unexpected mass immunizations	50% of applicable charges
	**Diabetes supplies ** **	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)
	**Tobacco cessation drugs and products ** **	No charge
	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.	

† 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****	
	• Routine prenatal visits	No charge
	• Routine postpartum visit	No charge
	• Delivery/hospital stay (uncomplicated)	$75 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**	
	• Medically indicated abortions	$20 per visit†
	• Elective abortions (including abortion drugs such as RU-486) limited to two per member per lifetime	$20 per visit†
	Family planning office visits	$20 per visit, except Women's Health benefits required by Health Care Reform at no charge
	Involuntary infertility office visits	$20 per visit
	Voluntary sterilizations for female members**	No charge
	In vitro fertilization*	20% of applicable charges
	Artificial insemination	$20 per visit
Emergency services**	At a facility within the Hawaii service area for covered emergency services	$75 per visit
	At a facility outside the Hawaii service area for covered emergency services	$75 per visit
Urgent care services**	At a Kaiser (or Kaiser-designated) urgent care center within the Hawaii service area for covered urgent care services	$20 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****	20% of applicable charges
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	$75 per day
Chemical dependency services**	**Chemical dependency** outpatient serivces, including office visits, day treatment and partial hospitalization services	Applicable office visit copay
	Chemical dependency hospital inpatient care, including non-hospital residential services	$75 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: • 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: • 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	20% of applicable charges
	Diabetes equipment	50% of applicable charges
	Home phototherapy equipment for newborns	No charge
	Breast feeding pump	No charge
	External prosthetic devices and braces, including speech generating devices and voice synthesizers	20% of applicable charges
Hearing aids**	**Hearing aids**, provided once every three years for each impaired ear	60% of applicable charges for standard hearing aids, per ear, every 3 years
	• Hearing test (audiogram) to determine hearing capabilities	$20 per visit
Pediatric services	**Pediatric vision care****, including: • One eye exam per calendar year • One pair of eye glass lenses per calendar year • One eye glass frame per calendar year (frame must be from ”value collection frames” available at Vision Essentials by Kaiser Permanente • One pair of non-disposable contact lenses or an initial supply of disposable contact lenses, not more than once every 12 months, in lieu of frames and lenses • Medically necessary contact lenses • One low vision hand-held or page magnifier device, every 24 months	No charge
	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).	Not covered
	Anesthesia and hospital services for dental procedures for children under age 9 with serious mental, physical, or behavioral problems	See applicable benefit sections (e.g.–office visit copay, inpatient care subject to hospital inpatient care copay, etc.)
Essential health benefits**	**Essential health benefits** are covered under this Service Agreement to the full extent required by law	See applicable benefit sections (e.g.–office visit copay, inpatient care subject to hospital inpatient care copay, etc.)
Dependent coverage**	Dependent (biological, step or adopted) children of the Subscriber (or the Subscriber’s spouse) are eligible up to the child’s 26th 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

† 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**

Out of Area Student Coverage	While attending an accredited educational institution in the United States and outside of the Kaiser Permanente's service areas on a full-time basis, members up to age 26 are covered for the following routine and primary care services:	
	• Up to 10 office visits per annual contract effective year for routine primary care	$20 per visit
	• Up to 10 combined outpatient basic laboratory services, basic imaging services, and testing services per annual contract effective year	
	• Basic laboratory services	$10 per day
	• Basic imaging services	$10 per day
	• Testing services	20% of applicable charges
	• Up to 10 prescriptions per annual contract effective year of self-administered drugs	20% of applicable charges

† 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, and 13) radiation therapy.
- 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: 1) a one-time only benefit at Kaiser Permanente, and 2) female members using spouse's sperm. 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, except when provided in accordance with the coverage for habilitative services. Speech-language pathology is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin, except when provided in accordance with the coverage for habilitative services. Habilitative services and devices develop, improve, or maintain skills and functioning for daily living that were never learned or acquired to a developmentally appropriate level. Skills and functioning for daily living, such as basic activities of daily living, are typically learned or acquired during childhood development. Habilitative services and devices include: 1) audiology services, 2) occupational therapy, 3) physical therapy, 4) speech-language therapy, 5) vision services, and 6) devices associated with these services including augmentative communication devices, reading devices, and visual aids, but exclude those devices used specifically for activities at school.

- **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 "Basic Health Services" can be applied toward the Supplemental Charges Maximum, if the item or service is covered under this Service Agreement: Essential Health Benefits, covered office visits for medical services listed in this Basic Health Services section, ambulance service, artificial insemination, blood or blood processing, braces, chemical dependency services, contraceptive drugs and devices, diabetes supplies and equipment, dialysis, drugs requiring skilled administration, durable medical equipment, emergency service, external prosthetics, family planning office visits, hearing aids, health evaluation office visits for adults, home health, hospice, imaging (including X-rays), immunizations (excluding travel immunizations), internal prosthetics, devices, and aids, in vitro fertilization procedure, infertility office visits, inpatient room (semi-private), interrupted pregnancy/abortion, laboratory, medical foods, mental health services, obstetrical (maternity) care, outpatient surgery and procedures, radiation and respiratory therapy, reconstructive surgery, self-administered/outpatient prescription drugs (in some cases, payments for self-administered/outpatient prescription drugs may not count toward the Supplemental Charges Maximum; Members may contact Kaiser Permanente's Customer Service Center for more information), short-term physical therapy, short-term speech therapy, short-term occupational therapy, skilled nursing care, 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, complementary alternative medicine (chiropractic, acupuncture, or massage therapy), dental services, dressings and casts, handling fee or taxes, health education services, classes or support groups, medical social services, office visits for services which are not Basic Health Services, radioactive materials, 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
Essential health benefits (EHBs)	**Essential Health Benefits (EHBs)** are benefits that the U.S. Department of Health and Human Services (HHS) Secretary defines as essential health benefits. EHBs include ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse 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 the EHB-benchmark plan. These EHBs are subject to change at any time to conform to applicable laws and regulations. This list is available through the Customer Service Center. *Note: This section describes EHBs that are not described in other parts of the benefit summary.*	
	Pediatric Oral Care services are only covered under this Kaiser Permanente contract if specifically provided by a separate dental rider.	Not covered
	Anesthesia and hospital services for dental procedures for children under age 9 with serious mental, physical, or behavioral problems	See applicable benefit sections (e.g.–office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.)
	Habilitative services and devices, when prescribed by a Kaiser Permanente physician • Habilitative services develop, improve, or maintain skills and functioning for daily living that were never learned or acquired to a developmentally appropriate level. Skills and functioning for daily living, such as basic activities of daily living, are typically learned or acquired during childhood development. • Habilitative services and devices include: ○ *Audiology services,* ○ *Occupational therapy,* ○ *Physical therapy,* ○ *Speech-language therapy,* ○ *Vision services, and* ○ *Devices associated with these services including augmentative communication devices, readying devices, and visual aids, but exclude those devices used specifically for activities at school.* • **Limitations:** ○ *Occupational therapy is limited to hand rehabilitation services, and medical services to achieve improved self care and other customary activities of daily living, except occupational therapy provided in accordance with covered habilitative services is covered.* ○ *Speech-language pathology is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin, except speech-language pathology provided in accordance with covered habilitative service is covered.* • **Exclusions:** ○ *Maintenance therapy. This exclusion does not apply to covered habilitative services.* ○ *Cardiac rehabilitation.* ○ *Long-term physical, occupational and speech therapy. This exclusion does not apply to covered habilitative services.* ○ *Applied behavioral analysis services.* ○ *Routine vision services. This exclusion does not apply to routine eye examinations nor does it apply to services that are required to be covered by state or federal law.*	See applicable benefit sections (e.g.–office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.)
	Services for the treatment of **Temporomandibular Joint Dysfunction (TMJ)**	See applicable benefit sections (e.g.–office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.)

† 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**

Benefits	You pay
Vision appliances and procedures for certain medical conditions *Note: Certain medical conditions include, for example, Keratoconus, Unilateral Aphake, Irregular Astigmatism, Distorted Corneas, Anisometropia >6D, and Infant Aphakia.*	See applicable benefit sections (e.g.–office visits subject to office visit copy, inpatient care subject to hospital inpatient care copy, etc.)

	Benefits	You pay
Drug rider 5/10/45	**For each prescription, when the quantity does not exceed:** • a 30-consecutive-day supply of a prescribed drug, or • an amount as determined by the formulary. **Self-administered drugs** are covered only when all of the following criteria are met: • prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate, • on the Health Plan Formulary. Senior Advantage members with Medicare Part D are entitled to drugs on the Health Plan Formulary and Kaiser Permanente Hawaii Medicare Drug Formulary. Drugs must be used in accordance with formulary 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.. **Maintenance drugs** are those which are used to treat chronic conditions, such as asthma, hypertension, diabetes, hyperlipidemia, cardiovascular disease, and mental health.	$5 per generic Maintenance drug prescription, $10 per prescription for all other generic drug prescriptions, and $45 per brand-name drug prescriptions
	Insulin	$10 per generic drug prescription and $45 per brand-name drug prescription
	Self-administered prescription drugs, including drugs for the treatment of cancer, are provided in accordance with state and federal law.	

Exclusions:

- 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 drug 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.

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 $5 for a generic Maintenance drug prescription, $10 each for all other generic drug perscriptions, and $45 for a brand-name drug 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 a Kaiser Permanente physician, 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.
   - 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.

Pediatric Vision Care (Essential Health Benefit)	Benefits	You pay
Pediatric Vision Care (optical care for pediatric Members up to age 19):		
	• Eye examination, once per calendar year	No charge
	• When prescribed by a Kaiser Permanente optometrist or physician, one pair of polycarbonate single vision, lined bifocal or lined trifocal lenses per calendar year	No charge
	• One frame per calendar year *Note: Frame must be from the "value collection frames" available at Vision Essentials by Kaiser Permanente clinic locations*	No charge
	• In lieu of frames and lenses, one pair of non-disposable contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing), not more than once every 12 months *Covered contact lenses include:* ◦ *Standard (one pair annually): one contact lens per eye (total of two lenses), or* ◦ *Monthly (six-month supply): six lenses per eye (total of 12 lenses), or* ◦ *Bi-weekly (three-month supply): six lenses per eye (total of 12 lenses), or* ◦ *Dailies (one-month supply): 30 lenses per eye (total of 60 lenses)*	No charge
	• When determined by a Kaiser Permanente physician, medically necessary contact lenses *Note: Contact lenses may be medically necessary and appropriate in the treatment of certain conditions such as Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular, and Astigmatism*	No charge
	• One low vision hand-held or page magnifier device (including fitting and dispensing), once every 24 months	No charge

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

SUMMARY OF DENTAL BENEFITS

Note: This brochure includes a brief description of your dental benefits. All benefits are governed by the provisions of Kaiser Foundation Health Plan, Inc's (KP) agreement with Hawaii Dental Service (HDS) and HDS's procedure code guidelines.

Hawaii Dental Service (HDS) 1801

Dependent age limit through age 26

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per calendar year (age 19 and over)	$1,200
DIAGNOSTIC	
• Examinations - once per calendar year	100%
• Bitewing x-rays - once per calendar year	100%
• Other x-rays (full mouth X-rays limited to once every 3 years)	70%
PREVENTIVE	
• Cleanings - twice per calendar year	100%
• Fluoride (once per calendar year through age 18)	70%
• Space maintainers (through age 18)	70%
RESTORATIVE	
• Amalgam (silver-colored) fillings	70%
• Composite (white-colored) fillings - limited to the anterior (front) teeth	70%
• Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	50%
Note: Composite (white) restorations or porcelain (white) crowns on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent - the patient is responsible for the cost difference up to the amount charged by the dentist.	
ENDODONTICS	70%
• Pulpal therapy	
• Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	70%
• Periodontal scaling and root planing (once every two years)	
• Gingivectomy, flap curettage and osseous surgery (once every three years)	
• Periodontal Maintenance - twice per calendar year after qualifying periodontal treatment	
PROSTHODONTICS	50%
• Fixed bridges (once every 5 years; ages 16 and older)	
• Dentures (complete and partial - once every 5 years; ages 17 and older)	
ORAL SURGERY (wisdom tooth extractions subject to medical necessity for Members through age 18)	70%
ADJUNCTIVE GENERAL SERVICES	70%
• Palliative treatment (for relief of pain, but not to cure)	

What you need to know about your Hawaii Dental Service (HDS) dental benefits

1. **Selecting A Dentist**
   In Hawaii, Guam and Saipan - Choose an HDS Participating Dentist
   You may select any dentist, however you save on your out-of-pocket costs when you visit an HDS participating dentist for services received in Hawaii, Guam and Saipan. HDS participating dentists have agreed to partner with HDS to make oral health care more affordable by limiting their fees to the Allowed Amount for services that are covered.

   About 95% of all licensed, practicing dentists in Hawaii participate with HDS, so it is more than likely your dentist is an HDS participating dentist. For a current listing of HDS participating dentists, visit the HDS website at www.deltadentalhi.org or call the HDS Customer Service department.

2. **What is an Allowed Amount?**
   Allowed Amount: The amount the participating dentist agrees to accept for services that are covered benefits.

3. **How is my payment calculated?**
   Calculating Your Benefit Payments
   Determining the amount you should pay your HDS participating dentist is based on a simple formula (see box below). HDS will pay the "% plan covers" amount.
   You are responsible for the balance owed to your participating dentist and any applicable deductible amount and taxes. Participating dentists are paid based upon their Allowed Amount.

Dentist's Allowed Amount X % plan covers
HDS Payment Dentist's Allowed amount <minus HDS Payment>
Patient Share

   It is important to note that when determining payment, HDS may consider your prior dental work performed under another plan and your current plan's limitations.

4. **How do I obtain services in Hawaii?**
   During your first appointment, advise your dentist that you are covered by Kaiser Foundation Health Plan Dental Care Program, Hawaii Dental Service (HDS) Group No. 1801, and present your HDS member identification card to your dentist. The submission of an accurately completed treatment form will expedite the processing time.

   Your participating dentist may submit a preauthorization request to HDS before providing services. With HDS's response, your dentist should explain to you the treatment plan, the dollar amount your plan will cover and the amount you will pay. This pre-authorization will reserve funds for the specified services against your Plan Maximum. It will also help you to plan your dental services accordingly should you reach your Plan Maximum.

   You will receive an HDS Explanation of Benefits (EOB) Report that provides payment information about the services you received from your dentist. It is important to note that the EOB report is not a bill. Depending on your dentist's practice, your dentist may bill you directly or collect any portion not covered by your plan at the time of service.

5. **If I am away from Hawaii, how do I obtain services?**
   On the Mainland - Choose A Delta Dental Participating Dentist
   HDS is a member of the Delta Dental Plans Association (DDPA), the nation's largest and most experienced dental benefits carrier with a network of more than 210,000 dentist locations.

   If your job takes you out of state or your child attends school on the Mainland, we recommend that you and/or your dependents visit a Delta Dental participating dentist to receive the maximum benefit from your plan.

For a list of Delta Dental participating dentists, visit the HDS website at www.deltadentalhi.org and click on "Members: Search for a Dentist," then "Delta Dental National Provider Database." Select "DeltaPremier" as your plan type and complete the remaining questions. Or you may call the HDS Customer Service department.

Visiting a Delta Dental Participating Dentist

- When visiting a dentist on the Mainland, let the dentist know that you have an HDS plan and present your HDS member identification card.
- If the dentist is a Delta Dental participating dentist, the claim will be submitted directly to HDS for you.
- Provide the dentist with the HDS mailing address and toll-free number located on the back of your member identification card.
- HDS's payment will be based upon the Delta Dental dentist's Allowed Amount.
- Your Patient Share will be the difference between the Delta Dental dentist's Allowed Amount and HDS's payment amount.

Visiting a Non-Participating Dentist
If you choose to have services performed by a dentist who is not an HDS or Delta Dental participating dentist, you are responsible for the difference between the amount that the non-participating dentist actually charges and the amount paid by HDS in accordance with your plan.

Because non-participating dentists have no agreement with HDS limiting the amount they can charge for services, your Patient Share is likely to be higher. Further, the amount reimbursed by HDS is generally lower if a non-participating dentist renders the services.

- On your first visit, advise the non-participating dentist that you have an HDS dental plan and present your HDS member identification card.
- In most cases you will need to pay in full at the time of service.
- The non-participating dentist will render services and may send you the completed claim form (universal ADA claim form) to submit to HDS. Mail the completed claim form for processing to:

  HDS - Dental Claims
  700 Bishop Street, Suite 700
  Honolulu, HI 96813-4196

- HDS payment will be based on the HDS non-participating dentist fee schedule and a reimbursement check will be sent to you along with your Explanation of Benefit (EOB) report.

Whether you visit a participating or non-participating dentist, please be sure to discuss the total charges and your financial obligations with your dentist before you receive treatment.

6. **How does HDS help manage costs?**
HDS participating dentists agree to limit their fees and charge the agreed upon fee even after the annual plan maximum has been reached.
Participating dentists may submit a preauthorization request to HDS before providing services. With HDS's response, the dentist should explain the treatment plan, the dollar amount that the plan will cover and the amount the member will pay.
This preauthorization will reserve funds for the specified services against the Plan Maximum. It will also help in planning the dental services accordingly should the Plan Maximum be reached.

How To Contact HDS

Register for online memeber information:
To register:

1. Log on at **www.deltadentalhi.org**
2. Click on "New User"
3. Complete the "Member Registration" form
4. Click on "Register User" button

HDS will then send the memeber an e-mail to activate the account.

HDS Website:
www.deltadentalhi.org

Visit the HDS website to search for a participating dentist, check your eligibility and plan benefits, access Explanation of Benefits (EOB) reports to view information about dental services you have received, or even print your membership identification card.

HDS DenTel
From Oahu: 545-7711
Toll-free: 1-800-272-7204

HDS DenTel is an automated phone service that allows HDS members to find out when they are eligible for coverage for their next dental visit, to obtain claims information, or even to have a summary of their plan benefits faxed or mailed to them, simply by following the prompts on the phone. Available everyday, 24 hours a day.

Customer Service Representatives:
Phone Line
From Oahu: 529-9248
Toll-free 1-800-232-2533 extension 248

Fax: 529-9366
Toll-free fax: 1-866-590-7988

Our local customer service representatives are available Monday through Friday from 7:30 a.m. - 4:30 p.m. Hawaii Standard Time.

Send written correspondence to:

Hawaii Dental Service
Attn: Customer Service
700 Bishop Street, Suite 700
Honolulu, HI 96813-4196

FRAUD AND ABUSE PROGRAM

Quality assurance is taken seriously at HDS. HDS periodically conducts reviews at HDS participating dentists' offices to ensure that members are being charged in accordance with HDS's contract agreements.

Confidential Fraud Hotline
From Oahu: (808) 529-9277
Toll-free: 1-800-505-9277
Email: HDSCompliance@hdsonline

This brochure 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 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 legal binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control.

	Benefits	You pay
Alternative medicine rider C - 12 visits / $20	**Chiropractic and acupuncture services** **Up to a combined maximum of 12 office visits per calendar year. This rider does not cover services which are performed or prescribed by a Kaiser Permanente physician or other Kaiser Permanente health care provider.** Services must be performed and received from Participating Chiropractors and Participating Acupuncturists of **American Specialty Health Networks (ASHN)**. Covered Services include: • **Chiropractic services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders which are authorized by ASHN and performed by a Participating Chiropractor. • **Acupuncture services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea or Pain Syndromes which are authorized by ASHN and performed by a Participating Acupuncturist. • **Adjunctive therapy** as set forth in a treatment plan approved by ASHN, may involve chiropractic modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation; acupuncture therapies such as acupressure, moxibustion, and cupping; and other therapies. • **Diagnostic tests** are limited to those required for further evaluation of the Member's condition and listed on the payor summary and fee schedule. Medically necessary x-rays, radiologic consultations, and clinical laboratory studies must be performed by either an appropriately certified Chiropractor or staff member or referred to a facility that has been credentialed to meet the criteria of ASHN. Diagnostic tests must be performed or ordered by a Participating Chiropractor and authorized by ASHN.	$20 copayment per office visit
	Chiropractic appliances when prescribed and provided by a Participating Chiropractor and authorized by ASHN.	Payable up to a maximum of $50 per calendar year
	Exclusions: • Any Chiropractic service or treatment not furnished by a Participating Chiropractor and not provided in the Participating Chiropractor's office. • Any Acupuncture service or treatment not furnished by a Participating Acupuncturist and not provided in the Participating Acupuncturist's office. • Examination and/or treatment of conditions other than Neuromusculo-skeletal Disorders from Participating Chiropractors and Neuromusculo-skeletal Disorders, Nausea, or Pain Syndromes from Participating Acupuncturists. • Services, lab tests, x-rays and other treatments not documented as medically necessary or as appropriate. • Services, lab tests, x-rays and other treatments classified as experimental or investigational. • Diagnostic scanning and advanced radiographic imaging, including Magnetic Resonance Imaging (MRI), CAT scans, and/or other types of diagnostic scanning or therapeutic radiology; thermography; bone scans, nuclear radiology, any diagnostic radiology other than plain film studies. • Alternative medical services not accepted by standard allopathic medical practices including, but not limited to, hypnotherapy, behavior training, sleep therapy, weight programs, massage therapy, lomi lomi, educational programs, naturopathy, podiatry, rest cure, aroma therapy, osteopathy, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing. • Vitamins, minerals, nutritional supplements, botanicals, ayurvedic supplements, homeopathic remedies or other similar-type products. • Nutritional supplements which are Native American, South American, European, or of any other origin.	

- Nutritional supplements obtained by Members through an acupuncturist, health food store, grocery store or by any other means.
- Traditional Chinese herbal supplements.
- Prescriptive and non prescriptive drugs, injectables and medications.
- Transportation costs, such as ambulance charges.
- Hospitalization, manipulation under anesthesia, anesthesia or other related services.
- Diagnostic tests, laboratory services and tests for Acupuncture.
- Services or treatment for pre-employment physicals or vocational rehabilitation.
- Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances (except as covered above in this brochure) or durable medical equipment.
- Services provided by a chiropractor or acupuncturist outside the State of Hawaii.
- All auxiliary aids and services, such as interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
- Adjunctive therapy not associated with acupuncture or chiropractic services.
- Services and/or treatment which are not documented as Medically Necessary services.
- Any services or treatment not authorized by ASHN, except for an initial examination.
- Any office visits beyond 12 per calendar year.

What you need to know about your alternative medicine benefits

1. **Do I need to see my Kaiser Permanente physician to obtain a referral for a Participating Chiropractor or Participating Acupuncturist?**
   No. These alternative medicine services do not require a Kaiser Permanente physician's approval.

2. **How do I choose a chiropractor or acupuncturist?**
   You may select any chiropractor or acupuncturist who participates with ASHN. You may obtain a list with their addresses and phone numbers by calling the Kaiser Permanente Customer Service Center at 432-5955 on Oahu, and 1-800-966-5955 on Neighbor Islands. You may also view the list by logging on to our website at www.kp.org.

3. **Will an X-ray be covered if it is ordered by my chiropractor and performed at a Kaiser Permanente location?**
   Only medically necessary X-rays authorized by ASHN are covered. The X-rays must be performed in either a Participating Chiropractor's office or an ASHN participating ancillary provider's office in order to be covered.

4. **How do I obtain chiropractic or acupuncture services in Hawaii?**
   Simply select a Participating Chiropractor or Participating Acupuncturist and call to set?up an appointment. At your appointment, present your Kaiser Foundation Health Plan membership information card and pay your designated copayment.