# Kaiser Foundation Health Plan, Inc.

**A NOT-FOR-PROFIT HEALTH PLAN – HAWAII MARKET**

## 2024 Summary of Important Changes for Contract Renewals for the Kaiser Permanente Group Plans

*(These changes are subject to regulatory approval)*

*The Evidence of Coverage (EOC) is the legally binding contract between Kaiser Foundation Health Plan and its members. The EOC includes the Kaiser Permanente Hawaii's Guide to your Health Plan, your employer's Group Agreement, riders, and amendments, if any. In the event of ambiguity, or a conflict between this summary and the EOC, the EOC shall control.*

*Please note that this summary does not fully describe your coverage.* For details on your coverage, please refer to your *Kaiser Permanente Hawaii's Guide to Your Health Plan (Guide).* This summary does not apply to Added Choice out-of-network coverage, Kaiser Permanente for Individuals and Families, Federal, State, Quest Integration or Medicare members.

*For specific questions about benefits, you may call our Member Services at 1-800-966-5955 (TTY 711).*

**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. **Orthodontic Care for the Treatment of Orofacial Anomalies (from birth).** For orthodontic care for the treatment of orofacial anomalies (from birth), the state of Hawaii Insurance Commissioner will increase the maximum benefit per treatment phase to $6,898 per calendar year (was $5,500).

**CONTRACT LANGUAGE CLARIFICATIONS** (that apply to all group plans)
*These clarifications are effective immediately, unless otherwise specified below.*

1. **Rehabilitation Services.** Clarify that rehabilitation services (such as pulmonary and cardiac) are covered when preauthorized in writing by Kaiser Permanente.
2. **No Surprises Act.** Revise language to add Post-Stabilization Care furnished by a non-Plan Provider, Independent Freestanding Emergency Department and Ancillary Service.

**PLAN-SPECIFIC COST SHARE CHANGES** (that only apply to specifically below-named plans)
*These changes become effective on your employer's contract renewal date, unless specified otherwise below.*

**KP Group**

- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

**KP Group $25 / $150 (20% LIT)**

- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

**KP Group $20 / 20% ($300)**

- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit after deductible (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

**KP HI Platinum 0/15**

- Outpatient basic labs and imaging will be $15 per day (was $10 per day).
- Hearing aids appliances will be 20% of Applicable Charges (was 60%).
- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

**KP HI Platinum 0/20**

- Hearing aids appliances will be 20% of Applicable Charges (was 60%).
- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

**KP HI Platinum 0/20 Rx Ded**

- Hearing aids appliances will be 20% of Applicable Charges (was 60%).
- Outpatient self-administered brand drugs will be covered at $75 per prescription (was $50).
- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

**KP Platinum Added Choice (in-network)** (formerly called KP Platinum Added Choice - $20)

- Hearing aids appliances will be 20% of Applicable Charges (was 60%).

**KP HI Gold 300/20 - B**

- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

# Kaiser Permanente Group Plan 401

# Benefit and Payment Chart

### 6608 BAYADA HOME HEALTH CARE, INC.

# About this chart

This benefit and payment chart:

- Is a summary of covered services and other benefits. It is not a complete description of your benefits. For coverage criteria, description and limitations of covered Services, and excluded Services, be sure to read *Chapter 1: Important Information, Chapter 3: Benefit Description*, and *Chapter 4: Services Not Covered*.
- Tells you if a covered service or supply is subject to limits or referrals.
- Gives you the page number where you can find the description of your services and other benefits.
- Tells you what your Cost Share is for covered services and supplies.

**Note:** Special limits may apply to services or other benefits listed in this benefit and payment chart. Please read the benefit description found on the page referenced by this chart.

You may only pay a single Cost Share for covered benefits you receive in the Total Care Service settings. If your care is not received in a Total Care setting, you pay the Cost Share for each medical service or item in accord with its relevant benefit section.

If a benefit in the Benefit and Payment Chart is not listed, or is listed as "Not covered", the descriptions related to that benefit in Chapters 1, 3, and 4 are not applicable.

Remember, services and other benefits are available only for care you receive when provided, prescribed, or directed by your KP Hawaii Care Team except for care for Emergency Services and out-of-state Urgent Care. To find a Medical Office near you visit our website at **www.kp.org**. For more information on these services see *Chapter 3: Benefit Description*. You are encouraged to choose a Personal Care Physician (PCP). You may choose any PCP that is available to accept you. Parents may choose a pediatrician as the PCP for their child.

You do not need a referral or prior authorization to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. Your Physician, however, may have to get prior authorization for certain Services. Additionally, in accord with state law, you do not need a referral or prior authorization to obtain access to physical therapy from a physical therapist or Physician who specialized in physical therapy.

Members age 65 and over (excluding Tax Equity and Fiscal Responsibility Act of 1982 "TEFRA" members) must meet the required eligibility requirements to receive the benefit of either 1) those listed in this *Benefit Summary*, or 2) benefits covered under Original Medicare. See *Chapter 9: Coordination of Benefits*. Senior Advantage Members, please refer to your Senior Advantage Evidence of Coverage.

| Description | Cost Share |
|---|---|
| **Annual Copayment Maximum** | |
| **Member** | $2,500 per calendar year |
| **Family Unit (3 or more members)** | $7,500 per calendar year |
| **Annual Deductible** | |
| **Member** | None per calendar year |
| **Family Unit (3 or more members)** | None |
| **Routine and Preventive** | |
| **Health Education and Disease Management** | |
| • Medical Office Visits | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Tobacco Cessation and Counseling Sessions | None |
| • Health education publications | None |
| • Healthy Living Classes | Applicable class fees |
| **Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))** | None |
| • Office visit for (CDC) Immunizations | None |
| • Office visit for Travel Immunization | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| **Medical Office Visits** | |
| • Well-Child Care | None |
| • Annual Preventive Care (physical exam) | None |
| • Hearing Exam (for correction) | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Vision Exam (for glasses) | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| **Preventive Screenings and Care** | None |
| **Total Health Assessment (www.kp.org)** | None |
| **Special Services for Women** | |
| **Preventive Care** | |
| • Annual Gynecological Exam | None |
| • Mammography (screening) | None |
| • Pap Smears (cervical cancer screening) | None |
| **Family Planning Visits** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| **Infertility Consultation** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| **In Vitro Fertilization** | 20% of applicable charges |
| **Maternity** | |
| • Maternity Care–routine prenatal visits in Medical Office | None |
| • Maternity Care–delivery | None |

| Description | Cost Share |
|---|---|
| • Maternity Care–one postpartum visit in Medical Office | None |
| • Maternity and Newborn Inpatient Stay | None |
| • Breast Pump | None |
| **Pregnancy Termination** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Voluntary Sterilization (including tubal ligation)** | |
| • Medical Office | None |
| • Total Care Settings | None |
| **Special Services for Men** | |
| **Vasectomy** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Settings |
| **Online Care** | |
| **My Health Manager (www.kp.org)** | None |
| **Medical Office Visits** | |
| **Medical Office Visits** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Routine pre-surgical and post-surgical | None |
| **Urgent Care Visits** | |
| • Within Service Area (Primary Care) | $15 per visit |
| • Outside Service Area | 20% of Applicable Charges |
| **Dependent Child Outside of Service Area** | |
| • Outpatient Care | $20 per visit for the first 10 visits, and 50% of Applicable Charges for additional visits |
| • Basic laboratory and general imaging | $10 per visit for the first 10 visits (combined total for laboratory, imaging, and testing), and 50% of Applicable Charges for additional visits |
| • Testing | 20% of applicable charges for the first 10 visits (combined total for laboratory, imaging, and testing), and 50% of Applicable Charges for additional visits |
| • Immunizations | None |
| • Contraceptive drugs and devices | None |
| • Self-administered drug prescriptions | 20% of applicable charges for the first 10 prescriptions, and 50% of Applicable Charges for additional prescriptions |
| **House Calls** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| **Telehealth** | Cost share, if applicable, will vary depending on service. |

| Description | Cost Share |
|---|---|
| **Laboratory, Imaging, and Testing** | |
| **Laboratory** | |
| • Basic | 10% of applicable charges |
| • Specialty | 10% of applicable charges |
| **Imaging** | |
| • Basic | 10% of applicable charges |
| • Specialty | 10% of applicable charges |
| **Testing** | |
| • Allergy Testing | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Skilled-Administered Drugs | 20% of applicable charges |
| • Diagnostic Testing | 10% of applicable charges |
| **Surgery** | |
| **Outpatient Surgery and Procedures** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Reconstructive Surgery** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Covered Mastectomy | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Total Care Services** | |
| *You may only pay a single Cost Share for covered benefits you receive in the following Total Care Service settings:* | |
| Inpatient Hospital Services | $75 per day |
| Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC) | $15 per visit |
| Emergency Services | $75 per visit in area, $75 per visit out of area. |
| Observation | None |
| Skilled Nursing Facility | None, up to 120 days per Accumulation Period |
| **Dialysis** | |
| • Dialysis | 20% applicable charges |
| • Equipment, Training and Medical Supplies for home Dialysis | None |
| **Radiation Therapy** | 20% of applicable charges |
| **Ambulance** | |
| **Air Ambulance** | 20% of applicable charges |
| **Ground Ambulance** | 20% of applicable charges |
| **Physical, Occupational, and Speech Therapy** | |
| **Physical and Occupational Therapy** | |
| • Medical Office | $15 per visit |
| • Home Health Care | None |
| • Total Care Settings | Included in Total Care Services |

| Description | Cost Share |
|---|---|
| **Speech Therapy** | |
| • Primary Care | $15 per visit |
| • Home Health Care | None |
| • Total Care Settings | Included in Total Care Services |
| **Home Health Care and Hospice Care** | |
| **Home Health Care** | None |
| **Hospice Care** | None |
| **Physician Visits** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| **Chemotherapy** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Internal, External Prosthetics Devices and Braces** | |
| **Implanted Internal Prosthetics, Devices and Aids** | |
| • Medical Office | None |
| • Total Care Settings | Included in Total Care Services |
| **External Prosthetics Devices** | |
| • Outpatient | 20% of applicable charges |
| • Total Care Settings | Included in Total Care Services |
| **Braces** | |
| • Outpatient | 20% of applicable charges |
| • Total Care Settings | Included in Total Care Services |
| **Durable Medical equipment** | |
| **Durable Medical equipment** | |
| • Outpatient | 20% of applicable charges |
| • Total Care Settings | Included in Total Care Services |
| **Oxygen (for use with DME)** | |
| • Outpatient | 20% of applicable charges |
| • Total Care Settings | Included in Total Care Services |
| **Repair or Replacement** | |
| • Outpatient | 20% of applicable charges |
| • Total Care Settings | Included in Total Care Services |
| **Diabetes Equipment** | 50% of Applicable Charges |
| **Home Phototherapy equipment** | None |
| **Behavioral Health–Mental Health and Substance Abuse** | |
| **Mental Health Care** | |
| • Medical Office | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Chemical Dependency Care** | |
| • Medical Office | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Autism Care** | |
| • Primary Care | $15 per visit |

| Description | Cost Share |
|---|---|
| • Specialty Care | $15 per visit |
| **Transplants** | |
| **Transplant Care for Transplant Recipients** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Transplant Care for Transplant Donors (based on health plan approval)** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| • Related Prescription Drugs | See prescription drugs in this *Benefit Summary* |
| **Transplant Evaluations** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| **Prescription Drug** | |
| **Skilled Administered Drugs** | 20% of applicable charges, (included in Total Care Services) |
| **Self-Administered Drugs** | If your employer has purchased a drug rider, coverage will be as specified in your drug rider following this *Benefit Summary* |
| **Chemotherapy Drugs** | |
| • Chemotherapy Infusion or Injections (Skilled Administered Drugs) | 20% of applicable charges |
| • Chemotherapy–Oral Drugs (Self-Administered Drugs) | 20% of applicable charges, or as specified in applicable drug rider |
| **Contraceptive Drugs and Devices** | 50% of applicable charges or none |
| **Diabetic Supplies** | 50% of Applicable Charges |
| **Tobacco Cessation Drugs and Products** | None (up to 30-day supply) |
| **Drug Therapy Care** | |
| **Growth Hormone Therapy** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Skilled-Administered Drug | 20% of applicable charges |
| • Total Care Settings | Included in Total Care Services |
| **Home IV/Infusion therapy** | |
| • Therapy and IV drugs | None |
| • Self-Administered Injections | See prescription drugs in this *Benefit Summary* |
| **Inhalation Therapy** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Miscellaneous Medical Treatments** | |
| **Blood and Blood Products** | |
| • Medical Office | None |
| • Rh Immune Globulin | 20% of applicable charges |
| • Total Care Settings | Included in Total Care Services |

| Description | Cost Share |
|---|---|
| **Dental Procedures for Children** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Hearing Aids** | |
| • Hearing Test | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Appliances | 20% of applicable charges |
| **Hyperbaric Oxygen Therapy** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Materials for Dressings and Casts** | Cost Share will vary upon place of service |
| • Total Care Settings | Included in Total Care Services |
| **Medical Foods** | 20% of Applicable Charges |
| **Medical Social Services** | None |
| **Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| **Rehabilitation Services** | |
| • Primary Care | $15 per visit |
| • Specialty Care | $15 per visit |
| • Total Care Settings | Included in Total Care Services |

| Description | Cost Share |
|---|---|
| **Additional services** | |
| **Prescribed Drugs, Self-Administered**<br><br>Generic Maintenance Drugs: $3 per prescription<br>Other Generic Drugs: $10 per prescription<br>Brand-Name Drugs: $45 per prescription<br>Specialty drugs: $200 | **4-Tier Prescription drug 3/10/45/200** |
| **Prescription drug mail-order incentive** | Two drug copayments for a 90-consecutive-day supply |
| **Special Services for Women** | |
| Artificial insemination (intrauterine insemination) | Same infertility cost share listed in the *Benefit Summary* in the front of this Guide |
| **Optical services** | Not included |
| **Dental services** | Hawaii Dental Services (HDS) Rider 1801 |
| Exam (twice per calendar year) | 100% of Allowed Amount |
| Bitewing X-rays (twice 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 |
| **Complementary Alternative Medicine** | |
| **Chiropractic and acupuncture services** (up to 20 visits per calendar year) | $20 per visit |
| **Fit Rewards (per calendar year)** | $200 gym membership or<br>$10 home fitness program |