Kaiser Foundation Health Plan, Inc.

Kaiser Permanente Hawaii's Guide to Your Health Plan

Individuals and Families
KP HI Standard Gold 1500/30 Off

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Benefit and Payment Chart

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 Chapter 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	Page #	Cost Share
Annual Copayment Maximum		
Member	13	$8,700 per calendar year
Family Unit	13	$17,400 per calendar year (for 2 or more members)
Annual Deductible		
Member	14	$1,500 per calendar year
Family Unit	14	$3,000 per calendar year (for 2 or more members)
Routine and Preventive		
Health Education and Disease Management		
• Medical Office Visits		
○ Primary Care	18	$30 per visit
○ Specialty Care	18	$60 per visit
• Tobacco Cessation and Counseling Sessions	18	None
• Health education publications	18	None
• Healthy Living Classes	18	Applicable class fees
Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))	19	None
• Office Visit for (CDC) Immunizations	19	None
• Office visit for Travel Immunization		
○ Primary Care	19	$30 per visit
○ Specialty Care	19	$60 per visit
Medical Office Visits		
• Well-Child Care	19	None
• Annual Preventive Care (physical exam)	19	None
• Hearing Exam (for correction)		
○ Primary Care	19	$30 per visit
○ Specialty Care	19	$60 per visit

Description	Page #	Cost Share
• Vision Exam (for glasses)		
○ Primary Care	20	$30 per visit
○ Specialty Care	20	$60 per visit
Preventive Screenings and Care	20	None
Total Health Assessment (www.kp.org)	21	None
Special Services for Women		
Preventive Care		
• Annual Gynecological Exam	21	None
• Mammography (screening)	21	None
• Pap Smears (cervical cancer screening)	21	None
Family Planning Visits		
• Primary Care	21	$30 per visit
• Specialty Care	21	$60 per visit
Infertility Consultation		
• Primary Care	22	$30 per visit
• Specialty Care	22	$60 per visit
In Vitro Fertilization	22	20% of Applicable Charges
Maternity		
• Maternity Care – routine prenatal visits in Medical Office	23	None
• Maternity Care – delivery	23	25% of Applicable Charges after deductible
• Maternity Care – one postpartum visit in Medical Office	23	None
• Maternity and Newborn Inpatient Stay	23	25% of Applicable Charges after deductible
• Breast Pump	23	None
Pregnancy Termination		
• Primary Care	24	$30 per visit
• Specialty Care	24	$60 per visit

Description	Page #	Cost Share
• Total Care Settings	30	Included in Total Care Services
Voluntary sterilization (including tubal ligation)		
• Medical Office	24	None
• Total Care Settings	30	None
Special Services for Men		
Vasectomy		
• Primary Care	24	$30 per visit
• Specialty Care	24	$60 per visit
• Total Care Settings	30	Included in Total Care Services
Online Care		
My Health Manager (www.kp.org)	24	None
Medical Office Visits		
Medical Office Visits		
• Primary Care	25	$30 per visit
• Specialty Care	25	$60 per visit
• Routine pre-surgical and post-surgical	25	None
Urgent Care Visits		
• Within Service Area	25	$45 per visit
• Outside Service Area	25	$45 per visit
Dependent Child Outside of Service Area		
• Routine Primary Care	26	$20 per visit
• Basic laboratory and general imaging	26	$10 per visit
• Testing	26	20% of Applicable Charges
• Immunizations	26	None
• Contraceptive drugs and devices	26	None
• Self-administered drug prescriptions	26	20% of Applicable Charges
House Calls		
• Primary Care	27	$30 per visit
• Specialty Care	27	$60 per visit

Description	Page #	Cost Share
Telehealth	27	Cost Share, if applicable, will vary depending on Service
Laboratory, Imaging, and Testing		
Laboratory		
• Basic	27	25% of Applicable Charges after deductible
• Specialty	27	25% of Applicable Charges after deductible
Imaging		
• General	28	25% of Applicable Charges after deductible
• Specialty	28	25% of Applicable Charges after deductible
Testing		
• Allergy Testing		
○ Primary Care	29	$30 per visit
○ Specialty Care	29	$60 per visit
• Skilled-Administered Drugs	29	20% of Applicable Charges
• Diagnostic Testing	29	$15 per test
Surgery		
Outpatient Surgery and Procedures		
• Primary Care	29	$30 per visit
• Specialty Care	29	$60 per visit
• Total Care Settings	30	Included in Total Care Services
Reconstructive Surgery		
• Primary Care	29	$30 per visit
• Specialty Care	29	$60 per visit
• Covered Mastectomy	29	25% of Applicable Charges after deductible
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
Total Care Services	30	
You may only pay a single Cost Share for covered benefits you receive in Total Care Service settings. Here are examples:		
Inpatient Hospital Services	30	25% of Applicable Charges after deductible
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	31	25% of Applicable Charges after deductible
Emergency Services	31	25% of Applicable Charges after deductible
Observation	35	25% of Applicable Charges after deductible
Skilled Nursing Facility	36	25% of Applicable Charges after deductible for 120 days per calendar year
Dialysis		
• Dialysis	36	20% of Applicable Charges
• Equipment, Training and Medical Supplies for home Dialysis	36	None
Radiation Therapy	36	20% of Applicable Charges
Ambulance		
Air Ambulance	36	20% of Applicable Charges
Ground Ambulance	37	20% of Applicable Charges
Physical, Occupational, and Speech Therapy		
Physical and Occupational Therapy		
• Medical Office	37	$30 per visit
• Home Health Care	37	None
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
Speech Therapy		
• Medical Office	38	$30 per visit
• Home Health Care	38	None
• Total Care Settings	30	Included in Total Care Services
Home Health Care and Hospice Care		
Home Health Care	38	None
Hospice Care	38	None
Physician Visits		
• Primary Care	38	$30 per visit
• Specialty Care	38	$60 per visit
Chemotherapy		
• Primary Care	39	$30 per visit
• Specialty Care	39	$60 per visit
• Total Care Settings	30	Included in Total Care Services
Internal, External Prosthetics Devices and Braces		
Implanted Internal Prosthetics, Devices and Aids		
• Medical Office	39	None
• Total Care Settings	30	Included in Total Care Services
External Prosthetics Devices		
• Outpatient	40	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Braces		
• Outpatient	41	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Durable Medical Equipment		
Durable Medical Equipment		
• Outpatient	41	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
Oxygen (for use with DME)		
• Outpatient	41	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Repair or Replacement		
• Outpatient	41	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Diabetes Equipment	42	50% of Applicable Charges
Home Phototherapy Equipment	42	None
Behavioral Health – Mental Health and Substance Abuse		
Mental Health Care		
• Medical Office	42	$30 per visit
• Total Care Settings	30	Included in Total Care Services
Chemical Dependency Care		
• Medical Office	43	$30 per visit
• Total Care Settings	30	Included in Total Care Services
Autism Care		
• Primary Care	44	$30 per visit
• Specialty Care	44	$60 per visit
Transplants		
Transplant Care for Transplant Recipients		
• Primary Care	44	$30 per visit
• Specialty Care	44	$60 per visit
• Total Care Settings	30	Included in Total Care Services
Transplant Services for Transplant Donors (based on health plan approval)		
• Primary Care	44	$30 per visit
• Specialty Care	44	$60 per visit
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
Related Prescription Drugs	45	See prescription drugs in this *Benefit Summary*
Transplant Evaluations		
• Primary Care	46	$30 per visit
• Specialty Care	46	$60 per visit
Prescription Drug		
Skilled Administered Drugs	46	20% of Applicable Charges; Included in Total Care Services
Self-Administered Drugs	46	See prescription drugs in this *Benefit Summary*
Chemotherapy Drugs		
• Chemotherapy Infusion or Injections (Skilled Administered Drugs)	47	20% of Applicable Charges
• Chemotherapy – Oral Drugs (Self-Administered Drugs	47	*Self-administered drug Cost Share (however, in accordance with State law, oral chemotherapy will be provided at the same or lower Cost Share as intravenous chemotherapy)*
Contraceptive Drugs and Devices	47	50% of Applicable Charges or None
Diabetic Supplies	47	50% of Applicable Charges
Tobacco Cessation Drugs and Products	48	None (up to 30-day supply)
Drug Therapy Care		
Growth Hormone Therapy		
• Primary Care	48	$30 per visit
• Specialty Care	48	$60 per visit
• Skilled-Administered Drug	46	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Home IV/Infusion therapy		
• Therapy and IV drugs	48	None
• Self-administered injections	48	See prescription drugs in this *Benefit Summary*

Description	Page #	Cost Share
Inhalation Therapy		
• Primary Care	48	$30 per visit
• Specialty Care	48	$60 per visit
• Total Care Settings	30	Included in Total Care Services
Miscellaneous Medical Treatments		
Blood and Blood Products		
• Medical Office	49	None
• Rh Immune Globulin	46	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Dental Procedures for Children		
• Primary Care	49	$30 per visit
• Specialty Care	49	$60 per visit
• Total Care Settings	30	Included in Total Care Services
Hearing Aids		
• Hearing Test		
○ Primary Care	50	$30 per visit
○ Specialty Care	50	$60 per visit
• Appliances	50	60% of Applicable Charges
Hyperbaric Oxygen Therapy		
• Primary Care	50	$30 per visit
• Specialty Care	50	$60 per visit
• Total Care Setting	30	Included in Total Care Services
Materials for Dressings and Casts	50	Cost Share will vary upon place of service
• Total Care Setting	30	Included in Total Care Services
Medical Foods	50	20% of Applicable Charges

Description	Page #	Cost Share
Medical Social Services	50	None
Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)		
• Primary Care	51	$30 per visit
• Specialty Care	51	$60 per visit
Rehabilitation Services		
• Primary Care	51	$30 per visit
• Specialty Care	51	$60 per visit
• Total Care Setting	30	Included in Total Care Services

Riders

Kaiser Foundation Health Plan, Inc. – Hawaii

KPIF ACA Amendment

This amendment is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this amendment.

Benefit Summary

Description	Cost Share
Physical, Occupational and Speech Therapy Habilitative Services	
• Medical Office	Same physical, occupational, and speech therapy Medical Office Cost Shares listed in the Benefit Summary in front of this Guide
• Home Health Care	Same home health care Cost Share listed in the Benefit Summary in front of this Guide
• Total Care Settings	Included in Total Care Services
Prescription Drugs Self-Administered Drugs in accord with USPSTF and PPACA	None
Special Services for Women Family Planning Visits in accord with PPACA	None
Behavioral Health – Mental Health and Substance Abuse Conditions listed in current DSM	Same behavioral health Cost Shares listed in the Benefit Summary in front of this Guide
Emergency Services Emergency services from dentists	Same emergency services Cost Shares listed in the Benefit Summary in front of this Guide

Description	Cost Share
Miscellaneous Medical Treatments	
Erectile Dysfunction	
• Primary Care	Same primary care Cost Share listed in the Benefit Summary in front of this Guide
• Specialty Care	Same specialty care Cost Share listed in the Benefit Summary in front of this Guide
• Total Care Settings	Included in Total Care Services
Temporomandibular Joint Dysfunction	
• Primary Care	Same primary care Cost Share listed in the Benefit Summary in front of this Guide
• Specialty Care	Same specialty care Cost Share listed in the Benefit Summary in front of this Guide
• Total Care Settings	Included in Total Care Services
Vision appliances and procedures	Cost Share will vary depending on service
Pediatric Vision Care	
• One eye exam	None
• One pair of eyeglasses (lenses and frame)	None
• One pair of non-disposable contact lenses (in lieu of eyeglasses)	None
• Medically necessary contact lens	None
• One low vision hand-held or page magnifier device	None
Pediatric Oral Care services are only covered under this Kaiser Permanente EOC if specifically provided by a separate dental rider bundled with this plan.	Not covered

Benefit Description

Physical, Occupational and Speech Therapy

Habilitative Services

We cover habilitative services and devices to 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, reading devices, and visual aids.

Prescription Drugs

Self-Administered Drugs in accordance with USPSTF

We cover U.S. Preventive Services Task Force (USPSTF) recommended drugs, including mail order, in accordance with the Patient Protection and Affordable Care Act provided the drug quantity prescribed does not exceed (i) a 30-consecutive-day supply, or (ii) an amount as determined by the Health Plan formulary. Mail order is provided up to a 90-consecutive-day supply to your home. The mail order program does not apply to certain pharmaceuticals (such as controlled substances as determined by state and/or federal regulations, bulky items, medication affected by temperature, injectables, and other products and dosage forms as identified by the Kaiser Permanente Pharmacy and Therapeutics Committee). Mail order drugs will not be sent to addresses outside of the Service Area.

Special Services for Women

Family Planning Visits

We cover family planning services in accordance with the Patient Protection and Affordable Care Act.

Behavioral Health – Mental Health and Substance Abuse

We cover conditions listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association that meet the standards of Medical Necessity.

Emergency Services from Dentists

We cover services of dentists only when the dentist performs emergency or surgical services that could also be performed by a Physician.

Miscellaneous Medical Treatments

Erectile Dysfunction

We cover services approved by Health Plan for the treatment of erectile dysfunction due to an organic cause.

Temporomandibular Joint Dysfunction (TMJ)

We cover services for the treatment of temporomandibular joint dysfunction (TMJ).

Vision Appliances and Procedures

We cover vision appliances, including eyeglasses and contact lenses and vision procedures for certain medical conditions when prescribed by a Physician.

Pediatric Vision Care

We cover pediatric vision care services for Members up to age 19, as follows:

- One eye examination per Accumulation Period.
  Please note: Additional eye exams are covered at the usual office visit Cost Share.
- When prescribed by a Kaiser Permanente Optometrist or Physician, one pair of polycarbonate single vision, lined bifocal or lined trifocal lenses per Accumulation Period.
- One frame every Accumulation Period. Covered frames must be from the "value collection frames" available at Vision Essentials by Kaiser Permanente clinic locations.
- (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 is provided at no charge. 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).

Medically necessary contact lenses, when determined by a Physician. 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.

One low vision hand-held or page magnifier device (including fitting and dispensing) is provided every 24 months.

Services Not Covered

Miscellaneous Exclusions

Habilitative Services: You are not covered for:

- Rehabilitation programs, unless referred by a Physician;
- Unskilled therapy;
- Routine vision services; and

- Duplicate services provided by another therapy or available through schools and/or government programs

Erectile Dysfunction: You are not covered for drugs, injections, equipment, supplies, prosthetics, devices and aids related to treatment of erectile (sexual) dysfunction, except as described in this Rider.

Additional Provisions

Miscellaneous Provisions

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 our Member Services department.

Health Plan certifies that this EOC covers Essential Health Benefits to the full extent required by law, except pediatric oral care services are not covered. Coverage for pediatric oral care should either be obtained via a stand-alone (independent) dental plan or via a "bundled" qualified health plan (QHP) purchased from Kaiser Permanente Hawaii Region (if purchased through us, the benefit will be described in the Benefit Summary in the front of this Guide), in accordance with applicable law. "Bundled" qualified health plans are medical plans that have been certified and approved as a QHP, in accordance with the Patient Protection and Affordable Care Act, and are bundled with a stand-alone exchange-certified pediatric dental plan from Hawaii Dental Service (HDS). Information regarding dental benefits should be obtained directly from HDS.

All other terms of coverage in this EOC applicable to Essential Health Benefits remain effective, including but not limited to the Exclusions and Limitations section of this EOC and the requirement that covered services be provided by or arranged by a Physician and be provided at a Medical Office, Hospital or Skilled Nursing Facility, except where such terms of coverage are specifically limited in this EOC (such as for emergency services) or would violate applicable law.

EHBs are provided upon payment of any applicable Deductible and Cost Shares listed in the Benefit Summary in the front of this Guide.

This section describes EHBs that are not described in other parts of this Guide. These EHBs are subject to all coverage requirements described in other parts of this EOC.

Payments toward EHBs count toward your Annual Copayment Maximum described in the Benefit Summary found in the front of this Guide, and Chapter 2: Payment Definitions and Information.

Kaiser Foundation Health Plan, Inc. – Hawaii
KPIF Standard Prescription Drug Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

Note: We also cover some outpatient drugs and supplies in the Prescription Drugs section in *Chapter 3: Benefit Description* of this Guide.

Benefit Summary

Description	Cost Share
Self-administered Prescription Drugs (member-purchased outpatient drugs at Kaiser Permanente Pharmacies)	
Generic drugs *	$15
Preferred Brand-name drugs *	$30
Non-Preferred Brand-name drugs *	$60
Specialty drugs *	$250
Refills through Mail-Order Program (for up to a 90-consecutive-day supply)	
Generic drugs	Two times the above-listed copay
Preferred Brand-name drugs	Two times the above-listed copay
Non-Preferred Brand-name drugs	Two times the above-listed copay
Specialty drugs *	$250
Insulin – Generic	$15
Insulin – Preferred Brand-name	$30
Annual Prescription Drug Copayment Maximum (on Pharmacy Dispensed Drugs)	
• Member	Not applicable
• Family Unit	Not applicable
Annual Prescription Drug Deductible	
• Applies only to these types of drugs	Not applicable
• Member	Not applicable
• Family Unit	Not applicable

* For up to a 30-consecutive-day supply per prescription, or an amount as determined by the Kaiser Permanente formulary.

Benefit Description

Self-administered Prescription Drugs
(member-purchased outpatient drugs at Kaiser Permanente Pharmacies)

Covered Drugs and Supplies
We cover self-administered prescription drugs and supplies only if all of the following conditions are met:

- prescribed by a KP physician or licensed Prescriber,
- is a drug for which a prescription is required by law, except for insulin,
- obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate,
- listed on the Kaiser Permanente formulary and used in accordance with formulary guidelines or restrictions, and
- is a drug which does not require administration by nor observation by medical personnel.

Notes: Immunizations are described in *Chapter 3: Benefit Description* under *Routine and Preventive.* Contraceptive drugs and devices are described in *Chapter 3: Benefit Description* under *Routine and Preventive.* Diabetic equipment and supplies are described in *Chapter 3: Benefit Description* under *Durable Medical Equipment (DME)* and *Prescription Drug*.

Cost Share for Covered Drugs and Supplies
When you get a prescription from a Kaiser Permanente Pharmacy, pharmacy we designate, or order a prescription from our Kaiser Permanente Mail-Order Pharmacy, you pay the Cost Share as shown in the above Benefit Summary. A reasonable charge is made for prescribed quantities in excess of the amounts described in the Benefit Summary. Each refill of the same prescription will also be provided at the same charge.

The Cost Share amounts count toward the Annual Copayment Maximum (or the Annual Prescription Drug Copayment Maximum if you have one listed in the above Benefit Summary). This applies for each covered prescription.

If you get a prescription from a non-Kaiser Permanente pharmacy, you will be responsible for 100% of the charges because it is not covered under this Prescription Drug Rider.

Day Supply Limit
The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-consecutive-day (or any other number of days) supply for you. Dispensing limitations may apply within the 30-consecutive-day supply period for certain drugs. When you pay the Cost Share shown in the Benefit Summary, you will receive the prescribed supply up to the day supply limit.

How to Get Covered Drugs or Supplies
Our pharmacies are located in most Kaiser Permanente clinics. To find a pharmacy, please see your Caring for You: Physicians and Locations Directory, visit kp.org, or contact Member Services. You must present your KP membership ID card, which has your medical record number, and a photo ID to the pharmacist.

Our mail-order pharmacy offers postage-paid delivery for refills of Maintenance drugs. Some drugs and supplies are not available through our mail-order pharmacy and/or not eligible for the mail-order cost share. Examples include but are not limited to controlled substances as determined by state and/or federal regulations, bulky items, drugs that require special handling or refrigeration, injectables, and other products and dosage forms as identified by the Kaiser Permanente Pharmacy and Therapeutics Committee. Drugs and supplies available through our mail-order pharmacy are subject to change at any time without notice. We are not licensed to mail medications out of state, so mail order drugs will not be mailed to addresses outside of the Service Area.

If you would like to use our mail-order pharmacy, use one of the methods below:

- Register and order online securely at **kp.org/refill**
- Call our Mail-order Pharmacy at **(808) 643-7979** (TTY **711**), Monday through Friday, 8 a.m. to 5 p.m.

Definitions

The following terms, when capitalized and used in this Prescription Drug Rider mean:

- ***Generic Drug.*** A drug that contains the same active ingredient as a Brand-Name Drug, is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent, and having the same active ingredients(s) as the Brand-name Drug. Generic Drugs are produced and sold under their Generic names after the patent of the Brand-Name drug expires. Generally, Generic Drugs cost less than Brand-Name Drugs, and must be identical in strength, safety, purity, and effectiveness.
- ***Non-Preferred Brand.*** A brand-name drug included on the Formulary (includes some Generic drugs), but is not preferred.
- ***Preferred Brand.*** A brand-name drug included on the Formulary.
- ***Specialty Drug.*** A very high-cost drug approved by the U.S. Food and Drug Administration (FDA).
- ***Annual Prescription Drug Copayment Maximum.*** (If not specified in this Benefit Summary, does not apply.) The Annual Prescription Drug Copayment Maximum is the maximum amount for Pharmacy Dispensed Drugs you pay out of your pocket in a calendar year. Once you meet the Annual Prescription Drug Copayment Maximum, you are no longer responsible for Cost Share amounts for covered Pharmacy Dispensed Drugs for the remainder of that calendar year.
    - "Pharmacy Dispensed Drugs" include all covered safe to self-administer pharmacy dispensed drugs, including but not limited to inhalers, insulin, chemotherapy drugs, contraceptive drugs/devices, and tobacco cessation drugs.
    - All incurred Cost Share and prescription drug deductibles (if applicable) for Pharmacy Dispensed Drugs count toward the Annual Prescription Drug Copayment Maximum, and are credited toward the calendar year in which they were received.
    - Note: The following medical items count toward the Annual Copayment Maximum and not the Annual Prescription Drug Copayment Maximum: skilled administered drugs, diabetes supplies to operate diabetes equipment, lancets, syringes, and drugs that are not dispensed from the pharmacy because they are not safe to self-administer.
    - Payments made by you or on your behalf for non-covered services, or for benefits excluded under this EOC do not count toward the Annual Copayment Maximum nor the Prescription Drug Copayment Maximum.
    - It is recommended that you keep receipts as proof of your payments. All payments are credited toward the calendar year in which the services were received.
- ***Annual Prescription Drug Deductible.*** (If not specified in this Benefit Summary, does not apply.) The Annual Prescription Drug Deductible is the amount you must pay for certain types of self-administered prescription drugs in a calendar year before we will cover those drugs. Once you meet the Annual Prescription Drug Deductible, you are no longer responsible for prescription drug deductible amounts for the remainder of the calendar year, and you pay the Cost Share shown in the Benefit Summary.
    - Each Member must meet the “per Member” Annual Prescription Drug Deductible, or the Family Unit must meet the “family unit” Annual Drug Deductible.

- The "per Member" Annual Prescription Drug Deductible amount counts toward the "per family unit" Annual Prescription Drug Deductible amount. Once the "per Member" Annual Prescription Drug Deductible is satisfied, no further Annual Prescription Drug Deductible will be due for that Member for the remainder of the calendar year. Once the "per family unit" Annual Prescription Drug Deductible is satisfied, no further "per Member" Prescription Drug Deductibles will be due for the remainder of the calendar year.
- The Annual Prescription Drug Deductible is separate from any other deductible that may be described in the Benefit Summary in the front of this Guide. Payments toward the Annual Prescription Drug Deductible do not count toward any other deductible. Consequently, payments toward any other deductible do not count toward the Annual Prescription Drug Deductible.
- Payments toward the Annual Prescription Drug Deductible also count toward the limit on Annual Prescription Drug Copayment Maximum.

About Our Drug Formulary

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/specialty drug unless this is prohibited by your Kaiser Permanente physician. If you want a brand-name/specialty 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 Kaiser Permanente physician deems a higher priced drug to be Medically Necessary when a less expensive drug is available, you pay the usual drug Cost Share. If you request the higher priced drug and it has not been deemed Medically Necessary, you will be charged Member Rates.

Note: If your prescription allows refills, there are limits to how early you can receive a refill. We will refill your prescription when you have used at least 75 percent of the quantity, unless otherwise directed by Kaiser Permanente. Please ask your pharmacy if you have questions about when you can get a covered refill.

Services Not Covered

- 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 *Chapter 3: Benefit Description* under *Prescription Drugs*.
- Drugs in the same therapeutic category as the non-prescription drug, as approved by the Kaiser Permanente Pharmacy & Therapeutics Committee.
- 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. This exclusion does not apply to diabetes supplies as described in *Chapter 3: Benefit Description* under *Diabetic Supplies*.
- Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate.
- Brand-name/specialty 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.
- Drugs not included on the Health Plan formulary, unless a non-formulary drug has been specifically prescribed and authorized by the licensed Prescriber.
- Drugs to shorten the duration of the common cold.
- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Drugs and supplies to treat sexual dysfunction.
- Drugs used to enhance athletic performance (including weight training and body building).
- Replacement of lost, stolen or damaged drugs or supplies.

Kaiser Foundation Health Plan, Inc. – Hawaii
Infertility Treatment Rider

This rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this rider.

Benefit Summary

Description	Cost Share
Special Services for Women	
Artificial insemination (intrauterine insemination)	Office visit copay

Benefit Description

Special Services for Women

Artificial Insemination

We cover artificial insemination (intrauterine insemination) to determine infertility status in accord with Medical Group requirements and criteria.

Kaiser Foundation Health Plan, Inc. – Hawaii

Kaiser Permanente Fit Rewards

This amendment is part of the *Guide to Your Health Plan* (Guide) to which it is attached. This amendment becomes part of *Chapter 5: Wellness and Other Special Features under the Extra Services section*. The provisions of this Guide and the Evidence of Coverage (EOC) apply to this amendment. Kaiser Permanente Fit Rewards is a value-added program and not part of your medical benefits.

Kaiser Permanente Fit Rewards® Program provides these extra services

Kaiser Permanente Fit Rewards – Calendar Year	**Basic Program fitness club and exercise center membership program** • Eligible Members may enroll with an American Specialty Health, Inc. (ASH) contracted network fitness club • Program enrollment includes standard fitness club services and features including access to cardiovascular equipment, access to resistance/strength equipment, access to classes which are routinely included in the general membership fee as part of the monthly fee, and for which the contracted fitness club does not typically require a fee per session, per week, per month, or some other time period; and where available, amenities such as saunas, steam rooms, and whirlpools. • Eligible Members should verify services and features with ASH contracted fitness club **Note:** • Eligible members must pay the Fit Rewards $200 annual program fee✦ • Eligible members must meet the 45-day, 30-minute per session activity requirement by end of calendar year 2024	**No Charge**
	Or	
	Home Fitness Program • Eligible Members may select up to one of the available ASH home fitness kits per calendar year	**$10** ✦
	Active&Fit website • All eligible Members have access to Active&Fit web-based services such as facility provider search, enrollment functions, educational content and fitness tools and trackers.	

The following are excluded from the Active&Fit Program:

- Instructor-led classes for which the ASH contracted fitness club charges a separate fee (and which are not routinely included in the general membership fee as part of the monthly membership fee).
- Personal trainers, classes, and club services, amenities, and products or supplies for which the ASH contracted fitness club charges Members an additional fee.
- Access to fitness or exercise clubs that are not part of ASH's contracted network.
- Home fitness kits not provided through ASH's Active&Fit program.
- Enrollment for Members not specifically listed as eligible for this program, as defined by the Group and Kaiser Permanente.
- Enrollment for Members under the age of 16.

✦ Members must pay their fee directly to ASH prior to using services. Kaiser Permanente Fit Rewards is a value-added service and not part of your medical benefits. Fees do not count toward the eligible Member's health benefit plan's Annual Copayment Maximum.

Kaiser Permanente shall not undertake to provide or to assure the availability and access to gym facilities approved by ASH.

Kaiser Permanente Fit Rewards is part of the Active&Fit Program, administered by American specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit and the Active&Fit logo are federally registered trademarks of ASH and used with permission herein. The details of this program are subject to change. For the most current details and specifics, please visit kp.org/fitrewards.