Kaiser Foundation Health Plan, Inc.

Kaiser Permanente Hawaii's Guide to Your Health Plan

Individuals and Families
KP HI Standard Silver 0/0 CSR 94

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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	$1,800 per calendar year
Family Unit	13	$3,600 per calendar year (for 2 or more members)
Annual Deductible		
Member	14	$0 per calendar year
Family Unit	14	$0 per calendar year (for 2 or more members)
Routine and Preventive		
Health Education and Disease Management		
• Medical Office Visits		
○ Primary Care	18	$0 per visit
○ Specialty Care	18	$10 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	$0 per visit
○ Specialty Care	19	$10 per visit
Medical Office Visits		
• Well-Child Care	19	None
• Annual Preventive Care (physical exam)	19	None
• Hearing Exam (for correction)		
○ Primary Care	19	$0 per visit
○ Specialty Care	19	$10 per visit

Description	Page #	Cost Share
• Vision Exam (for glasses)		
○ Primary Care	20	$0 per visit
○ Specialty Care	20	$10 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	$0 per visit
• Specialty Care	21	$10 per visit
Infertility Consultation		
• Primary Care	22	$0 per visit
• Specialty Care	22	$10 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
• Maternity Care – one postpartum visit in Medical Office	23	None
• Maternity and Newborn Inpatient Stay	23	25% of Applicable Charges
• Breast Pump	23	None
Pregnancy Termination		
• Primary Care	24	$0 per visit
• Specialty Care	24	$10 per visit
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
Voluntary sterilization (including tubal ligation)		
• Medical Office	24	None
• Total Care Settings	30	None
Special Services for Men		
Vasectomy		
• Primary Care	24	$0 per visit
• Specialty Care	24	$10 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	$0 per visit
• Specialty Care	25	$10 per visit
• Routine pre-surgical and post-surgical	25	None
Urgent Care Visits		
• Within Service Area	25	$5 per visit
• Outside Service Area	25	$5 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	$0 per visit
• Specialty Care	27	$10 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
• Specialty	27	25% of Applicable Charges
Imaging		
• General	28	25% of Applicable Charges
• Specialty	28	25% of Applicable Charges
Testing		
• Allergy Testing		
○ Primary Care	29	$0 per visit
○ Specialty Care	29	$10 per visit
• Skilled-Administered Drugs	29	20% of Applicable Charges
• Diagnostic Testing	29	$15 per test
Surgery		
Outpatient Surgery and Procedures		
• Primary Care	29	$0 per visit
• Specialty Care	29	$10 per visit
• Total Care Settings	30	Included in Total Care Services
Reconstructive Surgery		
• Primary Care	29	$0 per visit
• Specialty Care	29	$10 per visit
• Covered Mastectomy	29	25% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
Total Care Services		
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
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	31	25% of Applicable Charges
Emergency Services	31	25% of Applicable Charges
Observation	35	25% of Applicable Charges
Skilled Nursing Facility	36	25% of Applicable Charges 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	25% 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	$0 per visit
• Home Health Care	37	None
• Total Care Settings	30	Included in Total Care Services
Speech Therapy		
• Medical Office	38	$0 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

Description	Page #	Cost Share
Hospice Care	38	None
Physician Visits		
• Primary Care	38	$0 per visit
• Specialty Care	38	$10 per visit
Chemotherapy		
• Primary Care	39	$0 per visit
• Specialty Care	39	$10 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
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

Description	Page #	Cost Share
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	$0 per visit
• Total Care Settings	30	Included in Total Care Services
Chemical Dependency Care		
• Medical Office	43	$0 per visit
• Total Care Settings	30	Included in Total Care Services
Autism Care		
• Primary Care	44	$0 per visit
• Specialty Care	44	$10 per visit
Transplants		
Transplant Care for Transplant Recipients		
• Primary Care	44	$0 per visit
• Specialty Care	44	$10 per visit
• Total Care Settings	30	Included in Total Care Services
Transplant Services for Transplant Donors (based on health plan approval)		
• Primary Care	44	$0 per visit
• Specialty Care	44	$10 per visit
• Total Care Settings	30	Included in Total Care Services
Related Prescription Drugs	45	See prescription drugs in this *Benefit Summary*
Transplant Evaluations		
• Primary Care	46	$0 per visit
• Specialty Care	46	$10 per visit
Prescription Drug		
Skilled Administered Drugs	46	20% of Applicable Charges; Included in Total Care Services

Description	Page #	Cost Share
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 drugs will be provided at the same or lower Cost Share as intravenous chemotherapy drugs)*
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	$0 per visit
• Specialty Care	48	$10 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*
Inhalation Therapy		
• Primary Care	48	$0 per visit
• Specialty Care	48	$10 per visit
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
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	$0 per visit
• Specialty Care	49	$10 per visit
• Total Care Settings	30	Included in Total Care Services
Hearing Aids		
• Hearing Test		
○ Primary Care	50	$0 per visit
○ Specialty Care	50	$10 per visit
• Appliances	50	60% of Applicable Charges
Hyperbaric Oxygen Therapy		
• Primary Care	50	$0 per visit
• Specialty Care	50	$10 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
Medical Social Services	50	None
Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)		
• Primary Care	51	$0 per visit
• Specialty Care	51	$10 per visit
Rehabilitation Services		
• Primary Care	51	$0 per visit
• Specialty Care	51	$10 per visit
• Total Care Setting	30	Included in Total Care Services

This plan has been purchased through the Exchange.

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 *	$0
Preferred Brand-name drugs *	$15
Non-Preferred Brand-name drugs *	$50
Specialty drugs *	$150
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 *	$150
Insulin – Generic	$0
Insulin – Preferred Brand-name	$15
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.

Chapter 1: Important Information

- About this Kaiser Permanente Hawaii Guide to Your Health Plan
- Accessing Care
- Your Medical Office and PCP
- Your KP Hawaii Care Team
- Referrals and Prior Authorization
- Services and Benefits Generally
- 24/7 Advice Line
- Care While You Are Away from Home
- Questions We Ask When You Receive Care at Kaiser Permanente
- What You Can Do to Maintain Good Health
- Interpreting this EOC

About this Kaiser Permanente Hawaii Guide to Your Health Plan

Terminology

The terms You and Your mean you the Subscriber and/or your Family Dependents. We, Us, and Our refers to Kaiser Permanente.

The term Kaiser Permanente, KP, or Plan means our integrated health care delivery organization that provides the medical and hospital services to you. Kaiser Permanente is composed of Kaiser Foundation Health Plan, Inc., Hawaii region, (a nonprofit corporation), Kaiser Foundation Hospitals (a nonprofit corporation) and Hawaii Permanente Medical Group, Inc. (a for-profit professional corporation).

The term Personal Care Physician (PCP) means the Kaiser Permanente provider you choose to act as your personal health care manager.

The term Evidence of Coverage (EOC) means this Kaiser Permanente Hawaii Guide to your Health Plan (Guide), application/enrollment form, Riders, and amendments.

The term Service(s) means treatments, diagnosis, care, procedures, tests, drugs, injectables, facilities, equipment, items, or devices.

Definitions

Throughout the EOC, terms that are capitalized have the meanings shown in *Chapter 11: Glossary* at that end of this Guide.

Questions

If you have any questions, please call our Member Services department. More details about plan benefits will be provided free of charge. We list our telephone numbers in the back of this Guide.

Your HMO Plan

We are a health maintenance organization (HMO). HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury.

Our providers follow generally accepted medical practice when prescribing any course of treatment. We, our providers and our facilities work together to provide you with quality medical care Services. Our medical care program gives you access to all the covered Services you may need, such as routine Services with your own PCP, inpatient hospital, laboratory, pharmacy, and other benefits described in the *Benefit Summary* section at the front of this Guide, and *Chapter 3: Benefit Description*. In addition, our preventive care programs and health education classes offer you and your family ways to help protect and improve your health. See *Chapter 5: Wellness and Other Special Features*.

We provide or arrange for Services directly to you and your Family Dependents through an integrated medical care system. We require you to see specific physicians, hospitals, and other providers that are part of our network or who contract with us. These providers coordinate your health care Services. We are solely responsible for the selection of these providers. Contact us for a copy of our most recent provider directory, or visit our website at www.kp.org.

When you receive Services from Kaiser Permanente providers, you will not have to submit claim forms. You only pay the Deductible (if your plan has one) and Cost Shares described in this EOC. When you receive Emergency Services, Post-Stabilization Services that qualify as Emergency Services or Ancillary Services, the provider should send their bill directly to Us. When you receive out-of-area Urgent Care or Services covered under our Dependent Child out-of-area benefit from non-Kaiser Permanente providers, you may have to pay out-of-pocket for care and then file a claim to us for reimbursement. See *Chapter 7: Filing Claims for Payment*.

For further information about Member's Rights and Responsibilities, please visit our website at www.kp.org.

Kaiser Permanente's Pharmacy and Therapeutics Committee, composed of physicians, pharmacists and other providers, meet regularly to consider adding and removing prescription drugs on the drug formulary based on new information or drugs that become available. Drugs that meet the Committee's standards for safety, efficacy, ease of use, and value are included in our Kaiser Permanente formularies. For more information on coverage, see the *Benefit Summary* section in the front of this Guide, and *Chapter 3: Benefit Description.*

Accessing Care

Your Member ID Card

You must present your Kaiser Permanente member ID card, and a photo ID whenever you get Services. Your member ID card identifies you as a Kaiser Permanente member. If you misplace or lose your card, call Member Services so that a new card can be sent to you. Our phone numbers are listed in the back of this Guide.

Your PCP

The term Personal Care Physician (PCP) means the Kaiser Permanente provider you choose to act as your personal health care manager. Benefits are available only for care you receive from or arranged by your PCP. To find a Medical Office near you, visit our website at www.kp.org.

Your Medical Office and PCP

Medical Office

Your Medical Office is a group of providers from which all your Services are received. Your Medical Office is very important for two reasons:

- Your PCP works within your designated Medical Office; and
- If your condition requires the skills of a specialist, your PCP will arrange for you to get care from a specialty provider within the Medical Office (if available) or located at another facility.

PCP

Your PCP will act as your health manager, and will do the following:

- Advise you on personal health issues
- Diagnose and treat medical problems
- Coordinate and monitor any care you may require from appropriate specialists
- Keep your medical records up-to-date

We only cover medical Services, benefits, or supplies that are provided, prescribed or directed by a Physician, unless specified otherwise in the Services and Benefits section of this chapter. Your PCP is the first point of contact whenever you require medical assistance. Maintaining an ongoing relationship with your PCP will help ensure that you are receiving optimal care. Please check with your PCP for specific information about the requirements for receiving Services.

Your KP Hawaii Care Team

Choosing Your KP Hawaii Care Team

Your KP Hawaii Care Team is made up of you and both of the following:

- Your designated PCP
- Your designated Medical Office

To address individual health care needs, you and each of your Family Dependents may choose his or her own PCP and Medical Office.

When choosing a PCP and Medical Office, you should consider the following information:

- Do you already have a provider that you want to remain with? Read through the *Caring for You: Physicians and Locations Directory* to determine whether your current provider is available as a PCP.

- Decide what type of provider fits your needs (family practice, general practice, OB/GYN, internal medicine or pediatrics). For example, you may designate a pediatrician as the PCP for your child.
- Select a Medical Office that fits your needs (Medical Offices are in different locations and may offer different providers and specialties).
- Consider your personal preferences (a male or female provider, cultural issues and languages spoken).
- Call the Medical Office for more information (what are the office hours, what is their experience with certain diseases).

The Caring for You: Physicians and Locations Directory

This directory lists the names of each Medical Office and the PCPs and other providers located in that Medical Office. Copies of the directory are available by contacting Member Services at the phone number listed in the back of this Guide.

Please note: To provide you with the best care possible, the total number of patients a PCP can care for is limited. If the PCP you select cannot accept new patients without adversely affecting the availability or quality of Services provided, you will need to select someone else.

Changing Your KP Hawaii Care Team or PCP

Your PCP is responsible for providing and arranging all your medical care. Having a continuous relationship with your PCP allows you the best possible care. If you need to change your PCP, please call our Member Services department at the phone number listed in the back of this Guide, visit our website at www.kp.org, or write to Member Services at:

Member Services
Kaiser Foundation Health Plan
711 Kapiolani Boulevard
Honolulu, HI 96813

Referrals and Prior Authorization

In general, benefits are available only for care you receive from or arranged by your PCP, and at a Kaiser Permanente facility. A listing of Kaiser Permanente providers and facilities can be found at our website at www.kp.org or you may request a copy of the *Caring for You: Physicians and Locations Directory* from Member Services at the phone number listed in the back of this Guide.

Is the Service or Supply Subject to Prior authorization or Referral?

We provide or arrange for Services or supplies directly to you and your Family Dependents through an integrated medical care system. You must receive your health care from Kaiser Permanente providers and in Kaiser Permanente facilities within our Service Area except for these services:

- Written and authorized referrals (by a Kaiser Permanente provider and/or our Authorizations and Referrals department)

- Emergency care
- Out-of-state Urgent Care when traveling
- Certain Post-Stabilization Care Services that qualify as Emergency Services (under applicable federal law)
- Ancillary Services for which You have Prior Authorization except in an Emergency

Dependent child benefits (as described in this EOC) while out-of-state Your cost sharing for the above Services will be the same as if Kaiser Permanente providers provided such Services as set forth in the Benefit Summary.

Needing a Referral When Seeing a Specialist

Our PCPs offer primary medical, pediatric, and OB/GYN care. Kaiser Permanente Specialists provide specialty care in areas such as surgery, orthopedics, cardiology, urology, oncology, and dermatology. Your PCP will refer you to a Kaiser Permanente Specialist when appropriate. In most cases, you will need a referral to see a Kaiser Permanente Specialist for the first time. Your PCP will coordinate and monitor any care you may require from an appropriate Kaiser Permanente Specialist.

The Referral Process

- First, your PCP will look for a Physician or facility within Kaiser Permanente to treat you.
- If a specialty Physician or facility is not available within Kaiser Permanente, your PCP will refer you to a Physician or facility within the Kaiser Permanente contracted network of providers.

When you go to a specialty Physician's office or a facility, you should do both of the following;

- Present your Kaiser Permanente member ID card.
- Inform the Physician or nurse that you have been referred by your Kaiser Permanente PCP.

If, in the professional judgment of Medical Group, you require medical or hospital services covered by this EOC which require skills not available within Medical Group or facilities not available in Kaiser Permanente, and Medical Group determines that it would be in the best interest for you to obtain care from another source, then, upon written referral by Medical Group to the facility/practitioner designated by Medical Group, and upon you receiving prior written authorization by Kaiser Permanente, payment, in lieu of medical service benefits hereunder, is made for prescribed medical services within the coverage of this EOC. This may include referral to sources outside the Service Area, if deemed Medically Necessary by a Medical Group Physician and approved by Medical Group.

Your PCP will work with Health Plan and submit an administrative review request prior to services being rendered by a non-KP or out-of-state physician or facility. As an HMO, referrals are required before accessing service to avoid being responsible for the full cost of the medical services. Deductibles (if applicable) and Cost Shares for referred care are the same as those required for medical services provided by a KP provider. You will only be covered for the medical services listed as covered under this EOC. If your PCP does not provide or arrange for your services where a referral is required, you are responsible for the cost of the medical services.

Referral Limitations

Benefits for referred care are limited to those covered services described in this Guide. Should your provider recommend or perform services that are not covered by this Guide or do not meet payment determination criteria, or should a referral be suspended for quality of care or patient safety reasons, you are responsible for all charges related to the service. See the section *Questions We Ask When You Receive Care* later in this chapter.

Neighbor Island concierge

If you live on a neighbor island and your doctor refers you to a specialist, we may recommend you get treated on Oahu. For more information, contact Member Services at the phone number listed in the back of this Guide.

When a Referral is Not Needed

You do not need a referral from your PCP to make an appointment for obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. However, prior authorization may be required for certain services. To find participating health care professionals in your Medical Office who specialize in obstetrics or gynecology, visit our website at www.kp.org or contact Member Services at the phone number listed in the back of this Guide.

You do not need a referral from your PCP to obtain access to physical therapy from a health professional who specializes in physical therapy.

Making Appointments for Yourself for These Types of KP Providers

You don't need your PCP's referral to make appointments for the following services and departments: (Note: These services will be covered in accordance with your plan benefits)

- Eye examinations for glasses and contact lenses
- Family practice
- Health education
- Internal medicine
- Mental health and wellness
- Pediatrics
- Physical therapy
- Social work
- Sports medicine

Prior Authorization

"Prior authorization" means that we must approve the Services in advance in order for the Services to be covered.

You don't need prior authorization from us to get Emergency Care or out-of-state Urgent Care from Non-Kaiser Permanente providers or facilities. However, you must get prior authorization from us for Post-Stabilization Services from Kaiser Permanente providers and facilities.

"Post-stabilization Services" mean Services you receive for the acute episode of your Emergency Medical Condition after that condition is Clinically Stable. ("Clinically Stable" means that no material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during your discharge or transfer from the hospital).

With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), Clinically Stable means after delivery (including the placenta).

Claim Filing and Copayments

Non-Kaiser Permanente specialty physicians and facilities who provide care when you are referred by your PCP should forward all claims to us. When permitted by applicable law, We reserve the right to send benefit payments to you, to a provider, or if you have other coverage besides this plan, to the other carrier. You are responsible for your Deductible (if applicable) and Cost Shares. For a summary of your Deductibles or Cost Shares, see the *Benefit Summary* section in the front of this Guide, and *Chapter 3: Benefit Description.*

Services and Benefits Generally

Subject to the provisions of this EOC, Members receive services and benefits as follows:

Within the Service Area

- **Choice of Physician and Hospital.** Within the Service Area, covered medical Services are available only from Medical Group, Hospitals and in Skilled Nursing Facilities. Neither Health Plan, Hospitals, Medical Group nor any Physician has any liability or obligation for any medical Service or benefit sought or received by any Member from any other physician, hospital, skilled nursing facility, person, institution, or organization, unless such medical Services are covered as Emergency Services, or out-of-state Urgent Care described in *Chapter 3: Benefit Description*, or an authorized referral described in *Chapter 1: Important Information*.
- **Choice of Primary Care Provider.** You are encouraged to choose a PCP. You may choose any PCP available to accept Members. Parents may choose a pediatrician as the PCP for their child. Access to your PCP and other Physicians does not determine coverage for any particular services. Member shall be subject to pay for services at full charges for non-covered services.
- **Access to Obstetrical/Gynecological Care.** Members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Physician who specializes in obstetrics or gynecology. The Physician, however, may have to get prior authorization for certain Services.
- **Access to Physical Therapy.** In accord with state law, Members do not need a referral or prior authorization in order to obtain access to physical therapy from a physical therapist or Physician who specializes in physical therapy.

Outside the Service Area

Your benefits outside the Service Area are limited to:

- **Emergency Services or out-of-state Urgent Care** benefits described in the *Benefit Summary* section in the front of this Guide, and *Chapter 3: Benefit Description,*
- **Dependent Child outside the Service Area** benefits described in the *Benefit Summary* section in the front of this Guide, and *Chapter 3: Benefit Description*, and
- **Authorized referrals** as described in *Chapter 1: Important Information*.

24/7 Advice Line

For medical problems or questions after our facilities are closed, call our 24/7 Advice Line. Licensed care clinicians can provide advice or direct you to the appropriate place for care. You'll need to provide your medical record number (shown on the front of your Kaiser Permanente ID card) or the medical record number of the person for whom you're calling.

Care While You are Away from Home

Care Outside of Hawaii

We cover only limited health care services received outside our Service Area. As used in this section, "Care Outside of Hawaii" includes Emergency care (including Ancillary Services and Post Stabilization Services) and Urgent Care (and not follow-up care, routine care, and elective care) obtained outside our Service Area and Services provided to a Dependent Child outside the Service Area. Any other Services will not be covered.

Emergency and Urgent Care

For Emergency and Urgent Care outside of Hawaii, you should follow these steps:

- Carry your current member ID card for easy reference and access to service.
    - If you experience an Emergency while traveling outside Hawaii, go to the nearest Emergency facility.
    - For Urgent Care outside Hawaii, go to the nearest urgent care facility.

When you arrive at the provider, present your member ID card. For Urgent Care outside Hawaii, You may be responsible for paying the provider but then can file a claim for reimbursement from us. See C*hapter 7: Filing Claims for Payment*.

For non-Emergency and non-Urgent Care outside of Hawaii, you should contact our Member Services department to see if you have coverage other than Emergency and out-of-state Urgent Care.

Care on Neighbor Islands

For care on the neighbor islands, services are available by contacting the Medical Office on the island where you are located. *The Caring for You: Physicians and Locations Directory* lists the names of each Medical Office and the providers located in that Medical Office. Copies of the directory are available by contacting Member Services. Our phone numbers are listed in the back of this Guide. A service representative can help arrange your appointment and advise you of your Cost Share responsibility.

Care in another Kaiser Permanente service area

When you visit a different Kaiser service area, as a courtesy, you may receive visiting member care from designated providers in that area. Visiting member care is described in our *Visiting Member Services: Getting Care Away from Home* brochure. Visiting member care and your out-of-pocket costs may differ from the covered Services, Deductibles, and Cost Shares described in this Guide. Service areas and facilities where you may obtain visiting member care may change at any time.

For more information about visiting member care, including facility locations in other service areas, please call our Away from Home Travel Line at 951-268-3900 or visit our website at www.kp.org/travel.

Care for Dependent Children

In addition to the care described above, we provide a limited benefit to Family Dependent children up to age 26 who are outside all Kaiser Permanente's service areas and within the United States. For more information, see the *Benefit Summary* section at the front of this Guide, and *Chapter 3: Benefit Description.* You may need to pay for your care out-of-pocket, and then file a claim for reimbursement as described in *Chapter 7: Filing Claims for Payment.*

Questions We Ask When You Receive Care at Kaiser Permanente

Is the Care Covered?

To receive benefits, the care you receive must be a covered Service or supply. See the *Benefit Summary* section in the front of this Guide, and *Chapter 3: Benefit Description,* for a listing of covered Services and supplies. Also see *Chapter 4: Services Not Covered*.

What does Medically Necessary mean?

All covered Services you receive must meet all the following Medically Necessary criteria:

- Recommended by the treating PCP or Kaiser Permanente licensed health care practitioner,
- Is approved by the Kaiser Permanente's medical director or designee,
- 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,
- Is known to be effective in improving health outcomes/ provided that:
    - Effectiveness is determined first by scientific evidence;
    - If no scientific evidence exists, then by professional standards of care; and
    - If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
    - Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.
- And Services that are not known to be effective in improving health outcomes include, but are not limited to, Services that are experimental or investigational.

All covered Services must be Medically Necessary, prescribed, and consistent with reasonable techniques specified under this EOC with respect to the frequency, method, treatment, or licensing or certification to the extent the provider is acting within the scope of the provider's license or certification under applicable Hawaii State law.

Did You Receive Care from Your PCP or Kaiser Permanente Hawaii Care Team?

Benefits are available only for care you receive from or arranged by Kaiser Permanente Hawaii Care Team except as described in this Guide. To find a Medical Office near you, visit our website at www.kp.org. For more information see *Chapter 1: Important Information.*

Is the Service or Supply Subject to a Benefit Maximum?

A Benefit maximum is the maximum benefit amount allowed for a covered Service or supply. A coverage maximum may limit the duration, or the number of visits. For information about benefit maximums, read *Chapter 2: Payment Definitions and Information* and *Chapter 3: Benefit Description*.

Did You Receive Care from Provider Recognized by Us?

To determine if a provider is recognized by us, we look at many factors including licensure, professional history, and type of practice. All Kaiser Permanente providers and some non-network (affiliated) providers are recognized. To find out if your provider is recognized by us, refer to your *Caring for You: Physicians and Locations Directory*. If you need a copy, call us and we will send one to you or visit our website at www.kp.org.

What You Can Do to Maintain Good Health

Practice Good Health Habits

Staying healthy is the best way to control your health care costs. Take care of yourself all year long. See your provider early. Don't let a minor health problem become a major one. Take advantage of your preventive care benefits.

Routine and Preventive Services

Detecting conditions early is important. That's why Kaiser Permanente is committed to providing you with benefits for routine and preventive health services. Many serious disorders can be prevented by healthier lifestyles, immunizations, and early detection and treatment. Routine and preventive care should always be performed by your PCP.

Be a Wise Consumer

You should make informed decisions about your health care. Be an active partner in your care. Talk with your provider and ask questions. Understand the treatment program and any risks, benefits, and options related to it.

Interpreting this EOC (Evidence of Coverage)

The EOC between Kaiser Permanente and you are made up of all of the following:

- This Kaiser Permanente Hawaii Guide to Your Health Plan
- Any riders and/or amendments
- The application and/or enrollment form submitted to us

Our Rights to Interpret this Document

We arrange and provide medical services directly rather than paying for medical services provided by others. The interpretation of this EOC is guided by the direct service nature of the Health Plan program. Members designate Health Plan to be a fiduciary to review claims under this EOC. We will interpret the provisions of this EOC and will determine all questions that arise under it. We have the administrative discretion:

- To determine if you meet our written eligibility requirements;
- To determine the amount and type of benefits payable to you or your Family Dependents according to the terms of this EOC;
- To interpret the provisions of this EOC as is necessary to determine benefits, including decisions on Medical Necessity.

Our determinations and interpretations, and our decisions on these matters are subject to de novo review by an impartial reviewer as provided in the Arbitration section of this EOC or as allowed by law. If you do not agree with our interpretation or determination, you may appeal. See *Chapter 8: Dispute Resolution.*

No oral statement of any person shall modify or otherwise affect the benefits, limits and exclusions of this EOC, convey or void any coverage, or increase or reduce any benefits under this EOC.

Chapter 2: Payment Definitions and Information

- Applicable Charges
- Cost Share
- Annual Copayment Maximum
- Annual Deductible
- Member Rate
- Benefit Maximum
- Monthly Premiums and Terms of Coverage

Applicable Charges

Definition

For professional services, Applicable Charges mean:

- Member Rates when Medical Group or Kaiser Permanente Hospital provides medical Services,
- The negotiated rate when a contracted non-Kaiser Permanente provider or contracted non-Kaiser Permanente facility provides medical Services, or
- The fee that we determine to be usual, reasonable and customary when a non-contracted non-Kaiser Permanente provider or non-contracted non-Kaiser Permanente facility provides medical Services. This means a fee that:
    - Does not exceed the fees accepted as payment for similar Services by other providers; and
    - Is in accord with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

For other medical Services or items, Applicable Charges mean:

- Member Rates when Kaiser Permanente provides medical Services or items, or
- The negotiated rate, or the fee that we determine to be usual, reasonable and customary when medical Services or items are not provided by Kaiser Permanente. This means a fee that:
    - Does not exceed the fees accepted as payment for similar Services by other providers; and
    - Is in accord with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

Note: If you receive a non-covered Service, you are responsible for the entire amount charged by your provider.

Cost Share

Definition

A Cost Share applies to most covered Services. It is either a fixed percentage of Applicable Charges or a fixed dollar amount. In addition to Cost Share, and if your plan has a Deductible, please refer to the Annual Deductible information in this chapter, and see the *Benefit Summary* section in the front of this Guide to see if your plan has a Deductible, the amount, and what that Deductible applies to.

Annual Copayment Maximum

Definition

The Annual Copayment Maximum is the maximum amount you pay out of your pocket in a year. Once you meet the Annual Copayment Maximum you are no longer responsible for Cost Share amounts for eligible covered Services, unless otherwise noted under the *When You Pay More* section of this chapter.

See the *Benefit Summary* section in the front of this Guide to see what your Annual Copayment Maximum amount is.

When You Pay More

The following amounts do not apply toward meeting the Annual Copayment Maximum. You are responsible for these amounts even after you have met your Annual Copayment Maximum.

- Active&Fit or any fitness programs
- Bariatric surgery program
- Complementary alternative services such as chiropractic, acupuncture, massage therapy, or naturopathy
- Cosmetic plastic surgery
- Cosmetic dermatology
- Adult dental services
- Dressings and casts
- Health education services, classes or support groups
- Lasik eye surgery
- Medical social services
- Sexual dysfunction drugs
- Payments for services subject to a maximum once you reach the maximum. See Benefit Maximum later in this chapter.
- Take-home supplies
- Travel immunizations
- Any amounts you owe in addition to your Cost Shares for covered Services.
- Payments you make for non-covered, excluded, or exhausted Services

Note: It is recommended that you keep receipts as proof of your payments. All payments are credited toward the calendar year in which the medical services were received.

Annual Deductible

Definition

The Annual Deductible is the amount you must pay for certain covered medical Services in a calendar year before Kaiser Permanente will cover those Services. Once you meet the Annual Deductible, you are no longer responsible for deductible amounts for the remainder of the calendar year, and you pay the Cost Share for the covered Services. Each member Annual Deductible counts toward the family unit Annual Deductible amount. Most HMO Plans do not have a deductible. Amounts paid as Member Rates for non-covered benefits or services do not count toward payment of a Deductible. See the *Benefit Summary* section in the front of this Guide to see if your plan has a Deductible, the amount, and what that Deductible applies to.

How the Deductible Works

For each calendar year, only certain covered Services are subject to the Deductible, unless your plan does not have a Deductible. See the *Benefit Summary* section in the front of this Guide to see if your plan has a Deductible, the amount, and what that Deductible applies to.

For covered Services that are subject to the Deductible, Members must pay 100% of the Applicable Charges at the time the Service is received, until the Deductible is met. Each Member must meet the Member Deductible, or a Family Unit must meet the Family Unit Deductible. The Member Deductible and Family Unit Deductible are described in the *Benefit Summary* section in the front of this Guide. Each Member Deductible amount counts toward the Family Unit Deductible amount. Once the Member Deductible is satisfied, no further Deductible will be due for that Member for the remainder of the calendar year. Once the Family Unit Deductible is satisfied, no further Member Deductibles will be due for the remainder of the calendar year.

After the Deductible is met, Members must pay their Cost Shares for covered Services for the remainder of the calendar year, until their Annual Copayment Maximum has been met.

Amounts paid for covered Services that are received during the same calendar year and that are subject to the Deductible as indicated by this EOC, count toward the Annual Deductible.

Payments you make for non-covered, excluded, or exhausted Services do not count toward your Annual Deductible.

Member Rate

Definition

The Member Rate is the amount that we would charge you for a medical Service or item that is not covered. We determine the Member Rate by considering these factors:

- The cost of acquiring, storing, and/or dispensing the item.
- Increases in the cost of medical and non-medical Services in Hawaii over the previous year.
- The relative difficulty of the medical Service compared to other medical Services.

- Changes in technology.
- Payment for the medical Service under federal, state, or private insurance programs.

Benefit Maximum

Definition

A Benefit Maximum is a limit that applies to a specified covered Service or supply, when permitted by law. A Service or supply may be limited by duration, or number of visits. The maximum may apply per:

- Service. For example, in vitro fertilization is limited to a one-time only benefit while you are a Kaiser Permanente member.
- Year. For example, benefits for skilled nursing facility up to 120 days per year.

Where to Look for Limitations and Benefit Maximums

See the *Benefit Summary* section in the front of this Guide, *and Chapter 3: Benefit Description.*

Monthly Premiums and Terms of Coverage

Monthly Premiums

Monthly Premiums must be paid in advance. You must pay the correct amount specified by Health Plan before the beginning of a month to have coverage for that month. If you do not pay on time, we will send you a notice that you are in default. If you then do not pay the correct amount within the allotted time, we will terminate your membership and the membership of all the Members in your Family Unit. Only Members for whom Health Plan has received the appropriate Monthly Premiums are entitled to coverage under this EOC and then only for the period for which payment is received. Monthly Premiums will not be prorated and coverage is not retroactive.

Members of This Plan Who Become Eligible for Or Entitled to Medicare

After joining this plan, Members may become eligible for or entitled to coverage under Medicare (such as Parts A and/or B) due to age, disability or end stage renal disease. A Member who is or becomes eligible for coverage under Medicare should promptly contact Member Services at the phone number listed in the back of this Guide to give us notice of such eligibility and to receive information about our Senior Advantage Plan.

Payment in Error

If for any reason we make payment under this coverage in error, we may recover the amount we paid.

Outstanding Balances (deferral of non-urgent care)

We may reschedule future non-urgent appointments until after you have paid outstanding balances in full or have made other payment arrangements.

Missed Appointment Charge

We may impose an administrative charge of $15.00 for certain appointments (such as appointments with specialists) if your appointment is missed or not cancelled at least 24 hours in advance.

Payment of Cost Shares

Members must pay or arrange for payment of Cost Shares and any other amounts they owe Health Plan, Hospitals or Medical Group. Cost Shares are due at the time the Member receives medical services.

Chapter 3: Benefit Description

This Chapter Covers

Chapter 3: Benefit Description describes your covered Services. Benefits are available only for care you receive from or arranged by KP Hawaii Care Team, except for care for Emergency Services including Ancillary Services and Post-Stabilization Services (pursuant to federal law), or out-of-area Urgent Care or Dependent Child Coverage benefits. To find a clinic near you go to www.kp.org. You do not need a referral from your PCP to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. You may receive an annual gynecological exam from any Kaiser gynecologist or nurse midwife without a referral. For more information on these exceptions, refer to the benefit descriptions for each of these Services in this chapter. Be sure to read *Chapter 1: Important Information*. All information within *Chapter 1: Important Information* applies to accessing the Services described in this chapter. For coverage Cost Shares and excluded Services, be sure to also read the *Benefit Summary* in the front of this Guide and *Chapter 4: Services not Covered*. This chapter is divided into the following categories:

About this Chapter

- Routine and Preventive
- Special Services for Women
- Special Services for Men
- Online Care
- Medical Office Visits
- Laboratory, Imaging, and Testing
- Surgery
- Total Care Services
    - Inpatient Hospital
    - Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)
    - Emergency
    - Observation
    - Skilled Nursing Facility
    - Dialysis
    - Radiation Therapy
- Ambulance
- Physical, Occupational and Speech Therapy
- Home Health Care and Hospice Care
- Chemotherapy
- Internal, External Prosthetics Devices and Braces

- Medical Equipment and Supplies
- Behavioral Health - Mental Health and Substance Abuse
- Transplants
- Prescription Drugs
- Miscellaneous Medical Treatments

More About this Chapter

Your health care coverage provides benefits for procedures, Services or supplies that are listed in this chapter. You will note that some of the benefits have limitations. These limitations describe additional criteria, circumstances or conditions that are necessary for a procedure, Service or supply to be a covered benefit. These limitations may also describe circumstances or conditions when a procedure, Service or supply is not a covered benefit.

These limitations and benefits must be read in conjunction with Chapter 4: Services Not Covered, to identify all items excluded from coverage.

Note for Members on the Kaiser Permanente Silver Plan (Grandfathered Plan): Your plan does not cover most outpatient services (such as office visits, labs, and imaging). Please see your Benefit Summary in the front of this Guide. See also the end of Chapter 4: Services Not Covered for a list of additional exclusions specific to that plan.

Routine and Preventive

Health Education and Disease Management Programs

Covered, for the education in appropriate use of Health Plan services, and general health education publications distributed by Health Plan.

Covered, for general health education services (including diabetes self-management training and education) and disease management for members diagnosed with specific medical conditions such as asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and behavioral health conditions (mental health and substance abuse). These programs offer services to help you learn self-care skills to understand, monitor, manage and/or improve your condition. Covered, for tobacco cessation classes and counseling sessions.

We also provide programs available through our Healthy Living classes and resources. These classes are not covered benefits but are available upon payment of reasonable class fees. Healthy living classes and support groups include educational programs directed to members who wish to make changes in their behavior that reduce health risks and enhance the quality of their lives or maintain their level of health. Classes and support groups may include, but are not limited to: weight management, bariatric surgery program, stress management, and Lamaze. For more information, please see *Healthy Living* in *Chapter 5: Wellness and Other Special Features*, or visit www.kp.org/classes for a list of available classes and registration fees.

Immunizations

Covered, when authorized by KP. You are provided prescribed immunizations endorsed by the Centers for Disease Control and Prevention (CDC) for disease prevention, including Influenza and Pneumococcal, for unexpected mass populations, and for children 5 years of age and under (according to "prevailing medical standards" as defined by state law). Your office visits for CDC immunizations are provided without charge.

Immunizations for prevention of disease and unexpected mass populations must be:

- Routine vaccinations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Morbidity and Mortality Weekly Report (MMWR) by the Centers for Disease Control and Prevention (CDC) in accordance with published criteria, guidelines or restrictions, and
- On the Health Plan formulary and used in accordance with formulary guidelines or restrictions.

Note: consulting office visits for travel immunization are provided upon payment of your office visit Cost Share.

Medical Office Visits

Well-Child Care

Covered. Well-child office visits are provided without charge for Members at birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, and 5 years of age.

Note: all other office visits for health maintenance will be provided upon payment of your office visit Cost Share.

Preventive Care (Physical Exam)

Covered. You are provided without charge one preventive care (physical exam) office visit per calendar year for Members 6 years of age and over. Your coverage includes a variety of preventive care, which are meant to do one or more of the following:

- Protect against disease, such as in the use of immunizations;
- Promote health, such as counseling on tobacco use; and/or
- Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer.

If you have questions about coverage of medical services mentioned in this chapter, please see the *Benefits Summary* section at the front of this Guide or contact Member Services at the phone number in the back of this Guide.

Hearing Exam

Covered, to determine the need for hearing correction.

Vision Exam

Covered, to determine the need for glasses. We provide benefits for one routine vision exam per calendar year. A referral from your PCP is not necessary.

Preventive Screenings and Care

Preventive Screenings (applies to Grandfathered Plans)

You are covered for the following preventive screenings as determined by the Kaiser Permanente Prevention Committee's primary prevention for average risk guidelines such as:

- Anemia and lead screening for children
- Chlamydia detection
- Colorectal cancer screening
- Fecal occult blood test
- Lipid evaluation
- Screening mammography
- Newborn metabolic screening
- Osteoporosis screening
- Routine well-child screening
- Cervical cancer screening
- Diabetes screening

Preventive Care (applies to Non-Grandfathered Plans)

In addition to the preventive screening benefits listed above, if your plan is a Non-Grandfathered plan, you are covered for preventive care as determined by the Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) such as:

- Screening for Asymptomatic Bacteriuria in Adults
- Screening for Gonorrhea
- Screening for Hepatitis B Virus Infection
- Screening for HIV
- Screening for Syphilis Infection
- Screening for Iron Deficiency Anemia
- Screening for Rh (D Incompatibility)
- Screening for Congenital Hypothyroidism
- Screening for Phenylketonuria (PKU)
- Screening for Sickle Cell Disease in newborns
- Screening for Abdominal Aortic Aneurysm
- Prostate Specific Antigen (PSA) screening

You are covered for recommended preventive care for women developed by and supported by the Health Resources and Services Administration (HRSA) such as:

- Breast-feeding Support and Counseling – from a trained Physician or midwife during pregnancy and/or in the postpartum period.
- Contraceptive Counseling.
- Gestational Diabetes Screening.
- Human Papillomavirus (HPV) DNA Testing.
- Interpersonal and Domestic Violence Screening and Counseling.

The preventive care services list is subject to change at any time to conform to changes in applicable laws and regulations. This list is available on www.kp.org.

Total Health Assessment

Total Health Assessments are available for you and your covered Family Dependents age 18 and older through our free online healthy lifestyle program. For more information, please see *Total Health Assessments* in *Chapter 5: Wellness and Other Special Features*, or visit www.kp.org to start your Total Health Assessment today.

Special Services for Women

Preventive Care

Gynecological Exam

Covered. You may receive your annual gynecological exam from a Physician who specializes in obstetrics or gynecology without a referral or prior authorization.

The Physician, however, may have to get prior authorization for certain specialty services.

Mammography (screening)

Covered, as determined by the Kaiser Permanente Prevention Committee's primary prevention for average risk guidelines and recommended under the U.S. Preventive Services Task Force (USPSTF).

Your benefits for diagnostic mammography are described in another section of this chapter under *Imaging Services*.

Pap Smears (cervical cancer screening)

Covered, as determined by the Kaiser Permanente Prevention Committee's primary prevention for average risk guidelines and recommended under the U.S. Preventive Services Task Force (USPSTF).

Family Planning Visits

Covered, includes abortion counseling and information on birth control.

For Non-Grandfathered Plans, family planning services for female Members are provided in accordance with the ACA and covered at no charge.

Infertility Consultation

Covered, limited only to the initial consultation visit and labs and diagnostic tests prescribed during that visit.

In Vitro Fertilization

Covered, when provided or arranged by your PCP.

In vitro fertilization (IVF) is a complex series of procedures used to treat fertility or genetic problems and assist with the conception of a child. During IVF, mature eggs are collected (retrieved) from the Member's ovaries. In a laboratory, these eggs are fertilized by sperm provided by the Member's partner. The fertilized egg (embryo) is transferred (returned) to the uterus of the Member who originally supplied the eggs.

Your coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are a Kaiser Permanente Member. If you received benefits for in vitro fertilization under any Kaiser Permanente plan, you are not eligible for in vitro fertilization benefits under this plan. In vitro fertilization services are not covered when a surrogate is used. The in vitro procedures must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine's minimal standards for programs of in vitro fertilization.

To qualify for the IVF procedure as defined, you must prove that natural conception between your eggs and your partner's sperm have a five-year history of infertility or that infertility is related to one or more of the following medical conditions:

- Endometriosis;
- Exposure to utero to diethylstilbestrol (DES);
- Blockage or surgical removal of one or both fallopian tubes; or
- Abnormal male factors contributing to the infertility.
- You and your partner have been unable to attain a successful pregnancy through other covered infertility treatment.

If you do not have a history where you participated in natural conception using your own eggs and partner sperm, you must meet the following criteria to determine proper infertility:

- You are not known to be otherwise infertile, and
- You have failed to achieve pregnancy following three cycles of physician directed, appropriately timed intrauterine insemination.

You may be referred for these services to a specialized facility within Hawaii. See *Chapter 1: Important Information.* These services must have prior authorization.

Please note: In vitro fertilization not provided or approved by your PCP is not a covered benefit and you are responsible for payment. In vitro fertilization services include those services constituting the

complete in vitro fertilization and embryo transfer process. Benefits for services in connection with, but not included in the complete in vitro fertilization process, are covered elsewhere in this Guide.

Please note: Exclusions or limitations related to this benefit are described in *Chapter 4: Services Not Covered* in the section titled *Fertility and Infertility*.

Maternity

Maternity Care (for Members on a Non-Grandfathered Plan)

Covered, for routine prenatal visits, delivery, and one postpartum visit.

Coverage for other maternity related care such as nursery care, labor room, hospital room and board, pregnancy termination, diagnostic tests, labs, and radiology are described in other sections of this Guide.

Maternity and Newborn Inpatient Stay (for Members on a Non-Grandfathered Plan)

You have inpatient benefits for maternity as follows:

- 48 hours from time of delivery for a vaginal labor and delivery/ or
- 96 hours from time of delivery for a cesarean labor and delivery.

All newborns are covered for nursery care services described in this chapter for the first 48 or 96 hours after birth. For a description of covered services see the *Inpatient Hospital* section in this chapter. Newborns are covered after the first 48 or 96 hours if added to your coverage within 31 days of birth.

Newborns with congenital defects and birth abnormalities are covered for the first 31 days of birth even if not added to your coverage. These newborns are covered after 31 days of birth only if added to your coverage within 31 days of birth. See *Chapter 6: Membership Information.*

Maternity Care (for Members on a Grandfathered Plan)

Maternity care and Services (such as delivery, prenatal or postpartum care) are not covered under this plan.

Newborn Length of Stay (for Members on a Grandfathered Plan)

Newborns without congenital defects or birth abnormalities are covered from birth if added to your coverage (an enrollment form must be turned into us within 31 days of baby's birth). Newborns with congenital defects and birth abnormalities are covered for the first 31 days of birth even if not added to your coverage. These newborns are covered after 31 days of birth only if added to your coverage within 31 days of birth. See *Chapter 6: Membership Information.*

Breast Pump (for Members on a Non-Grandfathered Plan)

Covered, when prescribed by your Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan on a purchase basis, as determined by Health Plan, Medically Necessary and appropriate breast-feeding pump, including any equipment that is required for

pump functionality. Members on a Grandfathered Plan do not have coverage for durable medical equipment (including breast pump).

Pregnancy Termination

Covered. Your Cost Share for this service is determined based on the location of your service. If you receive your service in one of our Total Care Service settings, then your covered services and items are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Note: Coverage is limited to 2 elective pregnancy terminations of non-viable fetus per member's lifetime. Non-viability of the fetus is determined by Medical Group. This limit does not apply to medically indicated pregnancy terminations (determined by Medical Group) when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Voluntary Sterilization (including tubal ligation)

You are covered for voluntary sterilization, including tubal ligation. These services include:

- Sterilization surgery for women: trans-abdominal surgical sterilization
- Sterilization surgery for women: trans-cervical surgical sterilization implant
- Pre- and post-surgical visits associated with female sterilization procedures
- Hysterosalpingogram test following sterilization implant procedure

For Grandfathered plans, your Cost Share for this service is determined based on the location of your service. If you receive your service in one of our Total Care Service settings, then your covered services are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

For Non-Grandfathered Plans, voluntary sterilization for female Members is covered at no charge in accordance with the ACA.

Special Services for Men

Vasectomy

Covered, for surgery for vasectomy. Your Cost Share for this service is determined based on the location of your service. If you receive your service in one of our Total Care Service settings, then your covered services are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Online Care

My Health Manager (www.kp.org)

We provide multiple methods for you to access medical care conveniently when you need us anytime, anywhere. For more information, please see *My Health Manager* in *Chapter 5: Wellness and Other*

Special Features, or visit www.kp.org to get started today.

Medical Office Visits

Medical Office Visits

Medical Office Visits

Covered, for primary and specialty care visits at a Medical Office within the Service Area for evaluation and management which may include examination, history or medical decision making. Office visits also include consultations for surgical, obstetrical, pathological, radiological or other medical conditions, as determined by a Physician. You are covered for routine pre-surgical and post-surgical office visits, in connection with a covered surgery.

Urgent Care Visits

Covered. **Within the Service Area.** When you are within the Service Area, Urgent Care is available from our Physicians. Subject to certain limitations, your Health Plan will pay for Urgent Care received from medical practitioners other than our Physicians and in facilities identified by Health Plan for receipt of Urgent Care.

Outside the Service Area. Subject to certain limitations, Urgent Care you receive while you are temporarily outside the Service Area is available from medical practitioners other than Physicians and in facilities other than Health Plan-designated Hospitals.

Urgent Care means Medically Necessary care for a condition that requires prompt medical attention but is not an Emergency Medical Condition. The amount otherwise payable is reduced by:

- other Cost Shares or Deductibles that would be due if Urgent Care was received from Physicians or Hospitals or at Medical Offices, and by
- all amounts paid or payable, or which in the absence of this Guide would be payable, for the Urgent Care in question, under any insurance policy or contract, or any other contract, or any governmental program except Medicaid.

General Provisions

- Urgent Care includes prescription drugs required to treat you at the time of service.
- Reimbursement for Urgent Care required because of an act or omission or alleged act or omission of a third party, and the reimbursement for Urgent Care covered under the "Hawaii Motor Vehicle Insurance Law" or any other state or federal legislation of similar purpose are subject to the conditions stated in *Chapter 9: Coordination of Benefits*.
- When you claim reimbursement, you must complete and submit consents, releases, assignments, and other documents that Kaiser Permanente may reasonably request for the purpose of determining the applicability of and implementing Urgent Care.

Continuing or Follow-up Treatment

Continuing or follow-up treatment from a physician, hospital or other non-KP practitioner is not covered unless treatment meets the criteria for Urgent Care. Payment is limited to Urgent Care outside the Service Area which are required before you can, without medically harmful consequences, be transported to a KP facility in the Service Area, or, if you are near another KP Region, be transported to a

contracting hospital or medical office in the other KP Region, except that we at our option may continue inpatient coverage in lieu of transferring the Member. If you obtain prior approval from KP in the Service Area, covered benefits include the cost of necessary ambulance service or other special transportation arrangements medically required to transport you to a KP facility in the Service Area or to a contracted hospital or medical office in the nearest other KP Region for continuing or follow-up treatment. When directed by your KP Hawaii Care Team, ambulance service or other special transportation arrangements medically required to transport you to a KP facility in the Service Area or to a contracted hospital or medical office in the nearest other KP Region for continuing or follow-up treatment is provided without charge.

Notification and Claims

If you are admitted to a non-Kaiser Permanente facility, you (or your family), please notify us within 48 hours of any admission so that we are aware of your in-patient stay.

No claim pursuant to this Urgent Care benefit is allowed unless a complete application for payment, on forms provided by us, and is filed with us within 90 days after the first Emergency or Urgent Care for which payment is requested.

The 48-hour notice and 90-day filing requirements are not applied if done as soon as reasonably possible.

Releases and Assignments

Each Member claiming reimbursement hereunder shall complete and submit to us such consents, releases, assignments and other documents as we may reasonably request for the purpose of determining the applicability of and implementing this section.

Dependent Child Coverage Outside the Service Area

Covered, your Dependent Child who is outside of the Service Area is covered for these Medically Necessary services (the "Dependent Child Coverage Benefit") per Accumulation Period:

- Routine primary care, for up to 10 office visits
- Basic laboratory, general imaging, and testing (including interpretation) for up to combined maximum of 10 services
- Self-administered drug prescriptions, for up to 10 prescriptions
- Immunizations
- Contraceptive drugs and devices

The Dependent Child Coverage Benefit is subject to the following limitations:

- Primary care is limited to services provided by the following types of physicians: family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, and behavioral health (mental health and chemical dependence).
- Services must be prescribed and received during a covered routine primary care office visit.

- Immunizations limited to those recommended by the Advisory Committee on Immunization Practices (ACIP), in accordance with ACA.
- Contraceptive drugs and devices are limited to Federal Food and Drug Administration (FDA) approved contraceptive drugs and devices in accordance with ACA for up to a 30-day consecutive supply or cycle (whichever is less)
- Services can only be obtained outside of the Service Area and outside of all other Kaiser regions' service areas, at non-Kaiser Permanente facilities and with non-Kaiser Permanente health care providers.
- The Dependent Child may be required to pay for services at the point in time services are received and may need to file a claim for reimbursement by submitting the claim to Health Plan's claims department.
- The Dependent Child Coverage Benefit cannot be combined with any other benefit.
- Health Plan will not pay under the Dependent Child Coverage Benefit for a service Health Plan is covering under another section of this Guide such as Emergency Services, out of area Urgent Care, and referrals.
- Exclusions in *Chapter 4: Services Not Covered* apply.
- The Dependent Child Coverage Benefit does not apply to Medicare Members with Medicare as primary coverage.

House Calls

Covered, within the Service Area when a Physician determines that necessary care is best provided in the home. Physician house calls includes physician consultations and visits by a specialty physician.

Please note: benefits for home health care and hospice care are described in other sections of this chapter under Home Health Care and Hospice Care.

Telehealth

Covered to provide telecommunication services, such as video conferencing visits between the Member and the medical practitioner (including but not limited to specialists, primary care practitioners, and mental health practitioners). Services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time services were provided are subject to Cost Shares as described under applicable benefit sections. For example, office visits are subject to office visit Cost Shares.

Laboratory, Imaging and Testing

Laboratory

Covered, for prescribed basic and specialty laboratory services including interpretation of labs and related materials. If you receive covered laboratory services in one of our Total Care Service settings, then your covered services and items are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Examples of **basic lab** tests include:

- Thyroid test
- Throat cultures
- Urine analysis
- Fasting blood sugar and A1c for diabetes monitoring
- Electrolytes
- Drug screening
- Blood type and cross match
- Cholesterol tests
- Hepatitis B

Examples of **specialty lab** tests include:

- Tissue samples
- Cell studies
- Chromosome studies
- Pathology
- Testing for genetic diseases

Imaging

Covered, for prescribed general and specialty imaging including interpretation of imaging and related materials. If you receive covered imaging in one of our Total Care Service settings, then your covered imaging is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit. However, specialty imaging (including interpretation of imaging and related materials) is not included in Emergency Services and will be provided upon payment of your specialty imaging Cost Share.

Examples of **general imaging** include:

- X-ray
- Diagnostic mammography

Examples of **specialty imaging** include:

- Computerized tomography (CT) scan
- Interventional radiology
- MRI
- Nuclear medicine
- PET
- Ultrasound

Testing

Allergy Testing

Covered. We provide allergy treatment materials that require skilled administration by medical personnel that are on the Health Plan's formulary.

Diagnostic Testing

Covered, for prescribed diagnostic testing (including interpretation of tests) to diagnose an illness or injury. If you receive covered testing in one of our Total Care Service settings, then your covered testing is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Examples of diagnostic testing include:

- Electroencephalograms (EEG)
- Electrocardiograms (EKG or ECG)
- Pulmonary function studies
- Sleep studies
- Treadmills

Surgery

Outpatient Surgery and Procedures

You are covered for prescribed outpatient surgery and procedures done during an office visit at a Medical Office, including diagnostic colonoscopies. You are covered for routine pre-surgical and post-surgical office visits, in connection with a covered surgery. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Anesthesia

Covered, as required by a Physician or designate and when appropriate for your condition. Your Cost Share for anesthesia is determined based on the location of your service. If you receive anesthesia in one of our Total Care Service settings, then it is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Your anesthesia includes:

- General anesthesia.
- Regional anesthesia.
- Monitored anesthesia for high-risk Members as determined by a Physician.

Reconstructive Surgery

Covered, if a Physician determines that the reconstructive surgery is medically feasible and likely to:

- Result in significant improvement in physical function, including bariatric surgery and surgery to correct congenital anomalies,
- Correct a significant disfigurement resulting from an injury or Medically Necessary surgery, or
- To provide all stages of reconstructive surgery and an internally implanted breast prosthetic to produce a symmetrical appearance, that is incident to a covered mastectomy, if all or part of a breast is surgically removed for Medically Necessary reasons. If requested, an external prosthetic will be provided instead of an internally implanted breast prosthetic at the same Cost Share. Prosthetics must be prescribed by a Physician, obtained from sources designated by Health Plan, and meet the coverage definitions, criteria and guidelines established by Medicare at the time the prosthetic is prescribed. Treatment for complications of a mastectomy and reconstruction, including lymphedema, is also covered. (Please note: your Cost Share for the prosthetics is described in another section of this chapter under *Internal, External Prosthetics Devices and Braces*.)

Your covered surgeries include:

- Assistant surgeon care, as determined by a Physician or designate,
- Cutting surgery, and
- Non-cutting surgery, such as:
    - Diagnostic and endoscopic procedures,
    - Diagnostic and therapeutic injections including catheters, injections into joints, muscles, and tendons,
    - Orthopedic castings, and
    - Destruction of localized lesions by chemotherapy.
- Your Cost Share for surgery is determined based on the location of your service. If you receive your surgery in one of our Total Care Service settings, then it is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Total Care Services

Total Care Services are covered benefits you receive in one of our Total Care Service settings. Examples of Total Care Service settings are inpatient Hospital, outpatient surgery and procedures in a hospital-based setting or ambulatory surgery center (ASC), Emergency, observation, Skilled Nursing Facility, dialysis, and radiation therapy. When you receive a covered benefit in a Total Care Service setting, you may only pay a single Cost Share. Please see the description of benefits listed under each Total Care Service setting for your covered benefits.

Inpatient Hospital

You are covered for prescribed Hospital care, surgical procedures, hospital room and board (private room when Medically Necessary) and hospital ancillary services during your inpatient Hospital stay.

Your inpatient Hospital care includes:

- general nursing care and special duty nursing;
- Physicians' care;
- surgical procedures;
- respiratory therapy;
- anesthesia;
- medical supplies;
- use of operating and recovery rooms;
- intensive care room and related Hospital care;
- isolation care room and related Hospital care;
- Medically Necessary care provided in an intermediate care unit at an acute care facility;
- special diet;
- laboratory, imaging and testing;
- radiation therapy;
- chemotherapy;
- physical, occupational and speech therapy;
- administered drugs;
- internal prosthetics and devices;
- external prosthetic devices and braces ordinarily furnished by a Hospital;
- blood;
- durable medical equipment ordinarily furnished by a Hospital; and
- baby's newborn nursery care after birth in accord with the time periods specified in this chapter under *Maternity and Newborn Length of Stay*.

Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)

Covered. Prescribed outpatient surgical procedures, including reconstructive surgery for a covered mastectomy, and Physician services are included in your outpatient surgery (ASC) care.

Emergency Services

You are covered for Emergency Services within and outside of the Hawaii Service Area. The services you receive during an emergency room visit is included in your single Cost Share, except you pay an additional Cost Share for prescribed specialty imaging (including interpretation of imaging) and related materials as specified under the specialty imaging Cost Share.

If you are admitted directly to a hospital as an inpatient immediately following an Emergency visit, then we will waive your Emergency Services Cost Share and your inpatient hospital services Cost Share will apply. However, if you are admitted as anything other than hospital inpatient, then your applicable Emergency Services Cost Share will apply. For example, if you are admitted for observation following an Emergency visit, then the applicable Emergency Services and observation Cost Shares will apply.

An Emergency Medical Condition is defined to be a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Examples of an Emergency Medical Condition include chest pain or other heart attack signs, poisoning, loss of consciousness, convulsions or seizures, broken back or neck. Examples also include heavy bleeding, sudden weakness on one side, severe pain, breathing problems, drug overdose, severe allergic reaction, severe burns, and broken bones.

Examples of non-emergencies are colds, flu, earaches, sore throats, and using the emergency room for your convenience or during normal medical office hours for medical conditions that can be treated in a medical office.

Emergency Services are all of the following with respect to an Emergency Medical Condition:

- An appropriate medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act (section 1867 of the Social Security Act) ("EMTALA")) that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary care routinely available to the emergency department to evaluate the Emergency Medical Condition; and
- Within the capabilities of the staff and facilities available at the hospital, or Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA (or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department) to Stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
- Ancillary Services routinely available to the emergency department to evaluate or treat an Emergency Medical Condition are covered Emergency Services and shall not be subject to Prior Authorization requirements.
- Post-Stabilization Services furnished by a non-Plan Provider (including a nonparticipating emergency facility) are covered as Emergency Services AND
    - Your attending non-Plan Provider determines that You are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider within a reasonable travel distance, taking into account Your medical condition; or,
    - You (or your authorized representative) are not in a condition to receive, and/or to provide consent to, the non-Plan Provider's notice and consent form, in accordance with applicable state law pertaining to informed consent as determined by Your attending non-Plan Provider using appropriate medical judgment.

Stabilize is to provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), Stabilize means to deliver (including the placenta).

Note: Once Your condition is stabilized, covered Services that You receive are Post Stabilization Services and not Emergency Services EXCEPT when You receive Emergency Services from non-Plan Providers. Post-Stabilization Services are subject to all of the terms and conditions of this EOC including but not limited to Prior Authorization requirements when such Post-Stabilization Services are provided by Plan Providers that have a contractual obligation to obtain Prior Authorization AND that are contractually prohibited from balance billing you for such Post-Stabilization Services.

Medical Practitioners Other Than Physicians

If you receive covered Emergency Services from a medical practitioner other than a Physician, then Health Plan will pay the highest of the following amounts less your Emergency Services Cost Share:

- The median per-service amount (if any) that we have negotiated with Physicians for the service (this does not apply to capitation and other payment arrangements that are not on a per-service basis). If there is an even number of Physicians, the median is the average of the middle two negotiated amounts;
- The Applicable Charge; or
- The amount that would be paid for the service under Medicare Part A or Part B.

Unless prohibited by federal law, in addition to paying your Emergency Services Cost Share, you are responsible for paying any difference between the amount the provider bills and the amount Health Plan pays.

General Provisions

- Emergency Services include prescription drugs required to treat you at the time of service.
- Reimbursement for Emergency Services required because of an act or omission or alleged act or omission of a third party, and the reimbursement for Emergency Services covered under the "Hawaii Motor Vehicle Insurance Law" or any other state or federal legislation of similar purpose are subject to the conditions stated in *Chapter 9: Coordination of Benefits*.

Continuing or Follow-up Treatment

Continuing or follow-up treatment from a physician, hospital or other non-Kaiser Permanente practitioner is not covered unless treatment meets the criteria for Emergency Services. Payment is limited to Emergency Services including Post-Stabilization Services. Once your non-Plan Provider determines that you may be discharged, We may arrange for you to be transported to a Kaiser Permanente facility in the Service Area, or, if you are near another Kaiser Region, be transported to a contracting hospital or medical office in the other Kaiser Region, except that we at our option may continue inpatient coverage in lieu of transferring you. If you consent to receive such continuing or

follow-up care from the non-Plan Provider, then such Services will not be covered, and you will be financially liable.

If you obtain prior approval from us, covered benefits include the cost of ambulance or other special transportation arrangements required to transport you to a Kaiser Permanente facility in the Service Area or to a contracted hospital or facility in the nearest other Kaiser Region for continuing or follow-up treatment. When directed by your KP Hawaii Care Team, ambulance or other special transportation arrangements required to transport you to a Kaiser Permanente facility in the Service Area or to a contracted hospital or facility in the nearest other Kaiser Region for continuing or follow-up treatment is provided without charge.

Notification and Claims

If you are admitted to a non-Kaiser Permanente facility, we ask that you (or your family), your non-Kaiser Permanente provider, or someone else acting on your behalf notify us within 48 hours of any admission so that we are aware of your admission. When you receive Emergency Services from non-Plan Providers, Post Stabilization Services may qualify as Emergency Services pursuant to federal law. We will not require Prior Authorization for such Post-Stabilization Services at a non-Plan Hospital when your attending non-Plan Provider determines that, after You receive Emergency (screening and stabilization) Services, You are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider located within a reasonable travel distance taking into account Your medical condition.

If you can only be transported to a KP facility by an ambulance, we do not require prior authorization.

Non-Plan Providers may provide notice and seek Your consent (to waive your rights against surprise billing/balance billing under federal law) to provide Post-Stabilization Services or other covered Services. If you (or your authorized representative) consent to the furnishing of Services by non-Plan Providers, then You will be responsible for paying for such Services in the absence of any Prior Authorization.

Non-Plan Providers may provide a notice and consent form (to waive your rights against surprise billing/balance billing under federal law) seeking Your (or Your authorized representative's) agreement that You will owe the full cost of the bill for the items and services that the non-Plan Provider furnishes. If You (or Your Authorized Representative) consent, then You will be financially responsible for payment for those items and services.

We cover Post-Stabilization Services only when (1) they are provided by a non-Plan provider and considered to be Emergency Services under federal law (and no Prior Authorization requirement applies) or, (2) We determine that such Services are Medically Necessary pursuant to a Plan Provider's request for Prior Authorization for the Service.

Releases and Assignments

Each Member claiming reimbursement hereunder shall complete and submit to us such consents, releases, assignments and other documents as we may reasonably request for the purpose of determining the applicability of and implementing this Emergency Services benefit.

How to Access Emergency Services

If you need Emergency Services, call 911 or go to the nearest emergency room for care or Independent Freestanding Emergency Department. Emergency Services do not need prior authorization. Emergency Services for Emergency Medical Conditions are covered when provided by Physicians and medical practitioners anywhere in the world, as long as the services would have been covered under this section (subject to any exclusions listed in *Chapter 4: Services Not Covered* if received from Physicians).

Emergency Services are available from Kaiser Permanente emergency departments 24 hours a day, seven days a week.

Once at the emergency room or Independent Freestanding Emergency Department, you (or someone acting on your behalf) should do all of the following:

- Present your member card.
- Ask the physician or hospital to forward a copy to your medical care record to your PCP. Your PCP will review the emergency care, arrange for any necessary follow-up care, update your medical records, and be kept informed of your health status. Please tell your PCP about any specific emergency instructions given to you.
- Request that the physician or hospital file a claim with us.

Emergencies Outside of Hawaii

For emergencies in another state or country, these guidelines apply:

- Request that the non-Plan Provider(s) file a claim with us.

Please note: See *Chapter 1: Important Information, Care While You are Away from Home*.

Contacting Your PCP

If you are unable to contact your PCP before you get Emergency Services, you (or someone acting on your behalf) should contact your PCP to:

- Advise him or her of your condition, and
- Get instructions about follow-up care.

Please note: You should try to contact us within 48 hours after the illness or injury or as soon as reasonably possible.

Observation

Covered when prescribed by a Physician.

Skilled Nursing Facility

You are covered for prescribed skilled nursing care that is provided or arranged at approved facilities (including Hospitals or Skilled Nursing Facilities).

Skilled Nursing Care is defined as care within the limitations to the equipment and staff of a Skilled Nursing Facility and includes services and items such as:

- nursing care;
- room and board (including semi-private rooms);
- medical social services;
- medical supplies;
- durable medical equipment ordinarily furnished by a Skilled Nursing Facility; and
- external prosthetic devices and braces ordinarily furnished by a Skilled Nursing Facility.

Medicare guidelines are used to determine when care in a Skilled Nursing Facility is covered, except that a prior three-day stay in an acute care hospital is not required.

Dialysis (for all Members, except those on a KP Silver Grandfathered Plan)

Covered, for medical and Hospital care for acute renal failure and chronic renal disease. Dialysis for chronic conditions of Medicare Members is provided only in facilities certified by Medicare. Medical Group determines whether a condition is chronic or acute.

Covered, for equipment, training and medical supplies required for home dialysis. For routine dialysis and supplies to be covered, Member must satisfy all the medical criteria developed by Medical Group.

Dialysis is not covered for Members on the KP Silver (Grandfathered) Plan.

Radiation Therapy

Covered, for prescribed radiation therapy, such as radium therapy, radioactive isotope therapy, specialty imaging, and skilled administered drugs.

Ambulance

Air Ambulance

Covered, when received inside or outside the Service Area when deemed medically necessary by a Physician and all these statements are true:

- Ambulance is medically necessary if use of any other means of transport, regardless of the availability of such other means, would result in death or serious impairment of your health,
- Your condition requires Emergency Services,
- The air ambulance must be for the purpose of transporting you to the nearest medical facility designated by Health Plan for Medically Necessary acute care, and
- Your condition requires an air ambulance for safe transport.

Ground Ambulance

Covered, when received inside or outside the Service Area when deemed medically necessary by a Physician and all these statements are true:

- Ambulance is medically necessary if use of any other means of transport, regardless of the availability of such other means, would result in death or serious impairment of your health, and
- Your condition requires Emergency care.

Note: For air and ground ambulance directed by your KP Hawaii Care Team for continuing or follow up treatment, see *Emergency, Continuing or Follow-up Treatment.*

Physical, Occupational and Speech Therapy

Physical and Occupational Therapy

Covered in accord with our medical policy for short-term physical and occupational therapy. Changes to the policy may occur at any time during your plan year. Therapies are covered only when all the following are true:

- The diagnosis is established by the KP Health Care Team and the medical records document the need for skilled physical and/or occupational therapy.
- The therapy is ordered by the KP Health Care Team under an individual treatment plan.
- In the judgement of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy.
- The therapy is provided by, or under the supervision of a Physician-designated qualified provider of physical or occupational therapy. A qualified provider is one who is licensed appropriately and performs within the scope of his/her licensure.
- The therapy is skilled and necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury. Neurological and/or musculoskeletal function is sufficient when one of the following first occurs: i) neurological and/or musculoskeletal function is the level of the average healthy person of the same age, ii) further significant functional gain is unlikely, or iii) the frequency and duration of therapy for a specific medical condition as specified in Kaiser Permanente Hawaii's clinical practice guidelines has been reached.
- The therapy is short-term to restore neurological or musculoskeletal function required to perform normal activities of daily living, such as grooming, toileting, feeding, etc. Therapy beyond this is considered long-term and is not covered. Maintenance therapy is not covered.
- The therapy is not for deficits due to developmental delay.
- The therapy does not duplicate services provided by provided by another therapy or available through schools and/or government programs.
- The occupational therapy is limited to hand rehabilitation care, and medical care to achieve improved self-care and other customary activities of daily living.

Group exercise programs and group physical and occupational therapy exercise programs are available upon payment of reasonable class fees. See *Chapter 5: Wellness and Other Special Features* under *Healthy Living*.

Speech Therapy

Covered in accord with our medical policy for short-term speech therapy. Changes to the policy may occur at any time during your plan year. Speech therapy is covered only when all the following statements are true:

- The diagnosis is established by the KP Hawaii Care Team and the medical records document the need for skilled speech therapy services.
- The therapy is ordered by the KP Health Care Team.
- The therapy is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, or impairments of specific organic origin.
- The therapy is provided on a one-to-one basis.
- The therapy is used to achieve significant, functional improvement through objective goals and measurements. Therapy beyond this is considered long-term and is not covered. Maintenance therapy is not covered.
- The therapy is not for deficits due to developmental delay.
- The therapy does not duplicate service provided by another therapy or available through schools and/or government programs.

Home Health Care and Hospice Care

Home Health Care

Covered, when all these statements are true:

- Your KP Health Care Team determines that it is feasible to maintain effective supervision and control of your care in your home.
- Care is prescribed in writing by a Physician or directed by the Medical Group Home Health Committee to treat an illness or injury when you are homebound, as defined by Medicare.
- Home health care are Medically Necessary health care that can be safely and effectively provided in your home by healthcare personnel, and
- The attending Physician must approve a plan of treatment for you.

Note: You pay a Physician visit Cost Share for each Physician house call.

Benefit Limitation: Home health care is limited to care in the Service Area and only if a Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

Hospice Care

Covered. A Hospice Program provides care (generally in a home setting) for patients who are diagnosed as terminally ill and who have a life expectancy of six months or less. We follow Medicare guidelines and Kaiser Permanente hospice interdisciplinary team criteria to determine benefits, level of care and eligibility for hospice care. Your hospice care includes:

- Residential hospice room and board expenses directly related to the hospice care being provided. The hospice must be licensed and approved by Medical Group.

- Nursing care (excluding private duty nursing).
- Physical, respiratory, or occupational therapy, or therapy for speech language pathology.
- Medical social services.
- Home health aide care.
- Medical supplies and drugs.
- Physician care.
- Short-term inpatient care, limited to respite care and care for pain control and acute and chronic symptom management, in accord with Medicare guidelines.
- Hospice referral visits during which a patient is advised of hospice care options, regardless of whether the referred patient is later admitted to hospice care.
- Counseling and coordinating of bereavement services.
- Services of volunteers.

While under hospice care, the terminally ill patient is not eligible for traditional medical care covered under this plan, for the terminal condition, except hospice care and attending Physician office visits. The patient is eligible for all covered benefits unrelated to the terminal condition.

Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. The attending Physician must certify in writing that the patient is terminally ill and has a life expectancy of six months or less.

Note: You pay a Physician visit Cost Share for each Physician visit.

Chemotherapy

Covered, to treat infections or malignancy. Chemotherapy drugs must be FDA approved.

Internal, External Prosthetics Devices and Braces

Implanted Internal Prosthetics, Devices and Aids

Covered. Implanted internal prosthetics, devices and aids that are prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan. Your Cost Share for internal prosthetics is determined based on the location of your service. If you receive implanted internal prosthetics, devices and aids in one of our Total Care Service settings, then your internal prosthetic is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

The fitting and adjustment of these devices, including repairs and replacement other than those necessitated by misuse or loss are also provided.

Internal Prosthetics (such as pacemakers and hip joints) are those which meet all of the following criteria:

- Are used consistently with accepted medical practice and approved for general use by the federal Food and Drug Administration (FDA),

- 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,
- Were in general use on March 1 of the year immediately preceding the year in which the contract became effective or was last renewed, and
- Are not excluded from coverage by Medicare, and if covered by Medicare, meet the coverage definitions, criteria and guidelines established by Medicare at the time the device is prescribed.

Internal devices and aids include devices and aids such as surgical mesh, stents, bone cement, implanted nuts, bolts, screws and rods.

Your coverage is limited to the standard internal prosthetics, devices and aids in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.

External Prosthetics Devices (for Members on a Non-Grandfathered Plan)

External prosthetics are covered when prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan. External prosthetic devices and braces, and the fitting and adjustment of these devices and braces, including repairs and replacement other than those due to misuse or loss are provided upon payment of the applicable Cost Share. When provided in one of our Total Care Service settings, then external prosthetic devices and braces are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit. Members on a Grandfather Plan do not have coverage for external prosthetic devices (except as described in this Chapter related to a covered mastectomy).

Prosthetic devices are those which meets all of the following criteria:

- Are affixed to the body externally,
- are required to replace all or part of any body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ,
- were in general use on March 1 of the year immediately preceding the year in which this Guide became effective or was last renewed, and
- 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 prosthetic is prescribed.

When prescribed by a Physician, speech generating devices and voice synthesizers are provided, subject to the terms and the applicable Cost Shares. Examples of prosthetics include artificial limbs and eyes, post-mastectomy or post-lumpectomy breast prostheses, external pacemakers and post-laryngectomy electronic speech aids.

Covered for Grandfathered and Non-Grandfathered Plan, if all or part of a breast is surgically removed for Medically Necessary reasons, a prosthetic device following mastectomy is provided upon payment of the applicable Cost Shares. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.

Braces (for Members on a Non-Grandfathered Plan)

Covered. Your Cost Share for braces is determined based on the location of your service. If you receive your brace in one of our Total Care Service settings, then your covered brace is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Braces are those rigid and semi-rigid devices which:

- Are required to support a weak or deformed body member, or
- Are required to restrict or eliminate motion in a diseased or injured part of the body, and
- 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 brace is prescribed.

Your coverage is limited to the standard model of external prosthetic device or brace in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered. Members on a Grandfather Plan do not have coverage for Braces.

Medical Equipment and Supplies

Durable Medical Equipment (DME) (for Members on a Non-Grandfathered Plan)

Covered, when prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, Medically Necessary and appropriate durable medical equipment for use in the home.

We also cover:

- Oxygen for use in conjunction with prescribed durable medical equipment, and
- the repair, replacement and adjustment of durable medical equipment, other than due to misuse or loss.

Your Cost Share for DME is determined based on the location of your service. If you receive your DME in one of our Total Care Service settings, then your DME are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Examples of durable medical equipment include oxygen equipment, hospital beds, mobility assistive equipment (wheelchairs, walkers, power mobility devices), and insulin pumps.

Durable medical equipment is that equipment and supplies necessary to operate the equipment which meet all the following criteria:

- is intended for repeated use.
- is primarily and customarily used to serve a medical purpose.
- is appropriate for use in the home. Home means the place where you live other than a hospital or skilled or intermediate nursing facility.

- is generally not useful to a person in the absence of illness or injury.
- was a general use on March 1 or this year immediately preceding the year in which this contract became effective or was last renewed, and
- is not excluded from coverage from Medicare, and if covered by Medicare, meets the coverage definitions, criteria and guidelines established by Medicare at the time the durable medical equipment is prescribed.

If you rent or borrow any durable medical equipment items from Health Plan, then you must return the equipment to Health Plan or its designee or pay Health Plan or its designee the fair market price for the equipment when it is no longer prescribed by the Physician or used by you.

Your coverage is limited to the standard item of durable medical equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered. Members on a Grandfather Plan do not have coverage for durable medical equipment.

Diabetes Equipment

Covered, when prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, Medically Necessary. Diabetes equipment must also meet the DME criteria specified above. Diabetic supplies are covered under the Prescription Drugs section.

Home Phototherapy Equipment

Covered, when prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, Medically Necessary and appropriate home phototherapy equipment. Home phototherapy equipment must also meet the DME criteria specified above.

Behavioral Health – Mental Health and Substance Abuse

Mental Health Care

Covered. Your care will be provided under an approved individualized treatment plan. Your Cost Share for this care is determined based on the location of your service. When provided in the Medical Office, your outpatient care is provided upon payment of your office visit Cost Share. If you receive your care in one of our Total Care Service settings, then your covered care is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Your care includes:

- **Outpatient care**. Care by Physicians and mental health professionals that are performed, prescribed or directed by a Physician, including diagnostic evaluation, psychological testing, counseling and psychiatric treatment.

- **Inpatient Hospital care**. When prescribed by a Physician, Hospital care (include care by Physicians and mental health professionals) and the following medical care as prescribed by a Physician: room and board, psychiatric nursing care, group and individual therapy, electro-convulsive therapy, drug therapy, drugs and medical supplies while the Member is a registered bed patient in a Hospital.
- **Specialized Facility care**. When prescribed by a Physician, care in a specialized mental health treatment unit or facility approved in writing by Medical Group are covered as follows:
    - Day treatment or partial hospitalization care; and
    - Non-hospital residential care.

Chemical Dependency Treatment

Covered. Your care will be provided under an approved individualized treatment plan. Your Cost Share for this care is determined based on the location of your service. When provided in the Medical Office or in a specialized facility (for day treatment or partial hospitalization), your care is provided upon payment of your office visit Cost Share. If you receive your care in one of our Total Care Service settings, then your covered care is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Your care includes:

- **Detoxification**. Prescribed Medical and Hospital care for the medical management of the withdrawal process as long as deemed Medically Necessary by a Physician. Detoxification care includes coverage of outpatient care, inpatient care, and specialized facility care.
- **Outpatient care**. All care of Physicians and other health care professionals as performed, prescribed or directed by a Physician, including diagnostic evaluation and counseling provided at a Medical Office.
- **Inpatient Hospital care**. When prescribed by a Physician, Hospital care (includes all care of Physicians and other health care professionals) and the following care as prescribed by a Physician: Room and board, nursing care, group and individual therapy, drug therapy, drugs and medical supplies while the Member is registered bed patient in a Hospital.
- **Specialized Facility Care**. When prescribed by a Physician, care in a specialized alcohol or chemical dependence treatment unit or facility approved by writing by Medical Group are covered as follows:
    - Day treatment or partial hospitalization care, and
    - Non-hospital residential care.

Autism Care

Covered, in accord with Hawaii state law and when prescribed by a Physician. The Hawaii State law definitions of “applied behavioral analysis”, “autism”, “autism service provider”, “diagnosis of autism”, and “treatment for autism” will apply in this EOC. Your care must be provided under an approved treatment plan.

Your covered autism benefit is limited to:

- Diagnosis and treatment of autism and
- Applied behavioral analysis.

Transplants (for all Members, except those on a KP Silver (Grandfathered) Plan

Transplant care and Services are not covered for Members on the KP Silver (Grandfathered) Plan.

Transplants for Transplant Recipients

Covered, for medical and Hospital care. Your Cost Share for a transplant is determined based on the location of your service. When provided in the Medical Office, your transplant is provided upon payment of your office visit Cost Share. If you receive your transplant in one of our Total Care Service settings, then your covered transplant is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Transplant Services for Transplant Donors

Covered. Health Plan will pay for medical services for living organ and tissue donors and prospective donors if the medical services meet all 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 Health Plan Members.

Medical Services must meet all the following requirements:

- Regardless of whether the donor is a Member or not, the terms, conditions, and Cost Share of the transplant-recipient Member will apply. Cost Share for medical care provided to transplant donors is the responsibility of the transplant recipient Member to pay, and count toward the transplant-recipient Member's limit on Cost Share.
- The medical care is required is directly related to a covered transplant for a Member and required screening of potential donors, harvesting the organ or tissue, or treatment of complications resulting from the donation.
- For medical care to treat complications, the donor receives the medical care 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 care is provided not later than three months after the donation.
- The medical care is provided while the transplant recipient is still a Member, except that this limitation will not apply if the Member's membership terminates because the Member dies.
- Health Plan will not pay for travel or lodging for donors or prospective donors.
- Health Plan will not pay for medical care 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.

Transplants Covered

Your covered transplants are:

- Kidney transplants;
- Pancreas transplants;
- Heart transplants;
- Heart-lung transplants;
- Liver transplants;
- Lung transplants;
- Simultaneous kidney-pancreas transplants;
- Bone marrow transplants;
- Cornea transplants;
- Small bowel, and small bowel-liver transplants;
- Small bowel and multivisceral transplants; and
- Stem-cell transplants

Related Prescription Drugs

We cover prescribed post-surgical immunosuppressive drugs required as a result of a covered transplant. Your Cost Share for post-surgical immunosuppressive drugs are specified in the *Benefit Summary* under *Prescription Drugs* or an applicable drug rider.

Terms and Conditions

Your covered medical care and benefits are provided only in accord with the following terms and conditions:

- Medical Group determines that the Member satisfies medical criteria developed by Medical Group for receiving the medical care;
- Medical Group provides a written referral for care to a Medicare certified transplant or dialysis facility selected by Medical Group from a list of facilities it has approved;
- If, after referral, either Medical Group or the medical staff of the referral facility determines that the Member does not satisfy its respective criteria for the medical care involved, Health Plan's obligation under this benefit is limited to paying for covered medical care provided prior to such determination;
- Neither Health Plan, Medical Group nor Physicians undertake to provide a donor or a donor organ or bone marrow or cornea or to assure the availability of a donor or of a donor organ or bone marrow or cornea or the availability or capacity of referral transplant facilities approved by Medical Group; and
- Except for Medically Necessary ambulance transport is provided in accord with this Guide, neither transportation nor living expenses are covered for any person, including the Member.

Transplant Evaluations

Transplant evaluations approved by Health Plan are covered, subject to the terms and applicable Cost Shares (e.g., office visits, imaging, and testing, etc.). Transplant Evaluation means those procedures, including lab and diagnostic tests, consultations, and psychological evaluations, that a facility uses in evaluating a potential transplant candidate.

Prescription Drugs

Skilled Administered Drugs

Covered, for prescribed drugs that require skilled administration by medical personnel, such as injections and infusions. Your Cost Share for skilled administered drugs is determined based on the location of your service. If you receive your skilled administered drugs in one of our Total Care Service settings, then your skilled administered drugs are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit. The following criteria must be met:

- Prescribed by a licensed Prescriber.
- On the Health Plan formulary and need in accordance with formulary guidelines or restrictions, and
- The drug is one for which a prescription is required by law.

Note: Your Cost Share for immunizations, abortion drugs, and contraceptive drugs and devices are described elsewhere in this *Benefit Summary*.

Self-Administered Drugs

If your plan includes a drug rider, coverage will be as specified in your drug rider following this *Benefit Summary*.

Self-Administered Drugs determined by USPSTF

If your plan is a Non-Grandfathered plan, you are covered for self-administered drugs as determined by the Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF) at no charge 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.

Chemotherapy Drugs

Covered, for infusions or injections that require skilled administration by medical personnel, and self-administered oral chemotherapy drugs. In accordance with state law, oral chemotherapy drugs are provided at the same or lower Cost Share as intravenous chemotherapy.

Contraceptive Drugs and Devices

Covered (applies to Grandfathered Plans). Must be Federal Food and Drug Administration (FDA) approved contraceptive drugs and devices used to prevent unwanted pregnancies. Contraceptive drugs and devices include implants, injectables, oral, and intrauterine devices (IUDs). Note: The office visit to administer an implantable contraceptive device is the usual office visit Cost Share.

Covered (applies to Non-Grandfathered Plans). In addition to the coverage listed above, you are covered for FDA-approved contraceptive drugs and devices (in accordance with ACA) available on the Health Plan formulary at no charge, for up to a 30-consecutive-day supply or cycle (whichever is less). Note: The office visit to administer an implantable contraceptive device that is on the Health Plan formulary is no charge.

Must meet the following criteria:

- Prescribed by a licensed Prescriber,
- the drug or device is one for which a prescription is required by law, and
- obtained by pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, or a pharmacy we designated.

Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness.

No refund is given if an implant or device is removed.

Diabetic supplies

Covered, for up to a 30 consecutive–day supply. Diabetic supplies are limited to supplies necessary to administer insulin (syringes and needles) and to operate diabetes equipment (blood glucose test strips, lancets, and control solution).

The following criteria must be met:

- prescribed by a licensed Prescriber,
- on the Health Plan formulary and used in accordance with formulary guidelines or restrictions, and
- obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate.

Diabetes equipment are covered under the Medical Equipment and Supplies section.

Tobacco Cessation Drugs and Products

Covered. We provide up to a 30-consecutive supply of tobacco cessation drugs and products only when all of the following criteria are met:

- Prescribed by a licensed Prescriber,
- on the Health Plan formulary's Tobacco Cessation list of approved rugs, including approved over-the-counter and products, and in accordance with the formulary guidelines or restrictions,

- 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
- Member meets Health Plan approved program – defined requirements for smoking cessation classes or counseling.

Drug Therapy Care

Growth Hormone Therapy

Covered, if Medically Necessary. Your Cost Share for drug therapy is determined based on the location of your service. When provided in the Medical Office, your drug therapy is provided upon payment of your office visit Cost Share. If you receive your drug therapy in one of our Total Care Service settings, then your covered drug therapy is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Home IV/Infusion Therapy

Covered, prescribed home IV/infusion therapy care and prescription drugs that are self-administered intravenously (including biological therapeutics, biopharmaceuticals, or intravenous nutrient solutions needed for primary diet) under this Home IV/infusion therapy benefit. Self-administered injections are provided upon payment of your self-administered drug Cost Share.

Inhalation Therapy

Covered, for prescribed inhalation therapy. Your Cost Share for inhalation therapy is determined based on the location of your service. When provided in the Medical Office, your inhalation therapy is provided upon payment of your office visit Cost Share. If you receive your inhalation therapy in one of our Total Care Service settings, then your covered inhalation therapy is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Substitution

Health Plan pharmacies may substitute a chemical or generic equivalent for a brand-name drug unless prohibited by the licensed Prescriber. If a Member requests a non-formulary or brand-name drug for which there is a generic equivalent, the Member must pay Member Rates. If a Prescriber deems a higher priced drug to be Medically Necessary when a less expensive drug is available, the Member pays the usual drug copayment. However, if a Member requests the higher priced drug and it has not been deemed Medically Necessary by the Prescriber, the Member must pay Member Rates.

Mail Order Program

Members may purchase refills for self-administered FDA approved contraceptive drugs and devices, diabetes supplies and tobacco cessation drugs and products covered up to three cycles (contraceptives) or up to a 90 consecutive-day supply (diabetes supplies and tobacco cessation drugs and products) by mail order to the Members' home upon payment of an amount that Member would pay for two cycles (contraceptives) or a 60 consecutive-day supply (diabetes supplies and tobacco cessation drugs and products).

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 Pharmacy and Therapeutics Committee). Mail order drugs will not be sent to addresses outside of the Service Area.

Drug Manufacturer Coupon Program

When available, for outpatient prescription drugs and/or items that are covered under this Prescription Drugs section and obtained at a pharmacy owned and operated by Health Plan, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your Annual Copay Maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at www.kp.org/rxcoupons.

Miscellaneous Medical Treatments

Blood and Blood Processing

Covered, for blood, and blood processing including collection, processing and storage of autologous blood for a scheduled surgery when prescribed by a Physician whether or not the units are used. Blood is limited to units of whole blood, red cell products, cryoprecipitates, platelets, plasma, and fresh frozen plasma. Note: You pay the skilled administered drug Cost Share for Rh immune globulin.

Your Cost Share for blood is determined based on the location of your service. When provided in the Medical Offices, prescribed blood and blood processing is provided at no charge. If you receive your blood in one of our Total Care Service settings, then your covered blood is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Dental Procedures for Children

Covered, for anesthesia and hospital care for dental procedures for your child with serious mental, physical, or behavioral problems. Your Cost Share for this care is determined based on the location of your service. If you receive your care in one of our Total Care Service settings, then your covered care is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Hearing Aids (for Members on a Non-Grandfathered Plan)

Covered, for hearing test (audiogram) to determine hearing capabilities. You are also covered for hearing aids when prescribed by a Physician or Kaiser Permanente audiologist and obtained from sources designated by Health Plan. You are provided up to two hearing aids, one for each hearing-impaired ear, once every 36 months. Thereafter, a hearing aid(s) will be provided on the same basis 36

months after the hearing aid(s) was last provided. Members on a Grandfathered Plan do not have coverage for hearing aids and related Services.

Note: Your hearing aid(s) coverage is limited to the lowest priced model. If you purchase a hearing aid above the lowest priced model, then you will pay the copayment that you would have paid for the lowest priced model hearing aid(s) plus all additional charges for any amount above the lowest priced model hearing aid(s).

Hyperbaric Oxygen Therapy

Covered, for prescribed hyperbaric oxygen therapy. Hyperbaric oxygen therapy must be preauthorized in writing by Kaiser Permanente, except when used to treat an Emergency Medical Condition.

Your Cost Share for this therapy is determined based on the location of your service. When provided in the Medical Office, your therapy is provided upon payment of your office visit Cost Share. If you receive your therapy in one of our Total Care Service settings, then your covered therapy is included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Materials for Dressings and Casts

Covered. Your Cost Share for materials for dressings and casts is determined based on the location of your service. If you receive these items in one of our Total Care Service settings, then your covered items are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Medical Foods

Covered. Medical foods and low protein modified food products for the treatment of an inborn error of metabolism will be covered at your medical foods Cost Share when provided in accord with Kaiser Permanente's guidelines, and Hawaii law and its definitions.

Medical Social Services

Covered, medical social services are provided at Hospitals and selected Medical Offices. Medical social services include hospital discharge planning, patient education programs, and social services counseling.

Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)

Covered, when provided in accord with Kaiser Permanente's guidelines, and Hawaii law and its definitions. Orthodontic care will be limited to Members under 26 years of age for the treatment of orofacial anomalies resulting from birth defects or birth defect syndromes.

When prescribed by a Physician, orthodontic care for treatment of orofacial anomalies resulting from birth defects or birth syndromes are covered, subject to terms and Cost Shares. Orthodontic care is covered to a maximum benefit per treatment phase set annually by the insurance commissioner for the applicable calendar year. (For example, Member will be responsible for all charges after Health Plan paid the maximum benefit or $6,898 per treatment phase.)

Rehabilitation Services

Covered, for prescribed rehabilitation services (such as pulmonary and cardiac) when preauthorized in writing by Kaiser Permanente. Your Cost Share for rehabilitation services is determined based on the location of your service. When provided in the Medical Office, rehabilitation services are provided upon payment of your office visit Cost Share. If you receive your rehabilitation services in one of our Total Care Service settings, then your covered rehabilitation services are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit.

Services Related to Clinical Trials

For Non-Grandfathered plans, you are covered for Services received in connection with a clinical trial when you meet our conditions. Your Cost Share is determined based on the location of your service. When provided in the Medical Office, Services are provided upon payment of your office visit Cost Share. If you receive Services in one of our Total Care Service settings, then your covered Services are included in a single Cost Share according to your Total Care Service benefits. Please see *Total Care Services* in the *Benefit Summary* for your Cost Share for this benefit. For coverage of Services received in connection with a clinical trial, you must meet all of the following conditions:

- We would have covered the services if they were not related to a clinical trial.
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
    - A Physician makes this determination.
    - You provide us with medical and scientific information establishing this determination.
        - If we participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through us unless the clinical trial is outside the state where you live.
        - The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
    - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
    - The study or investigation is a drug trial that is exempt from having an investigational new drug application.
    - The study or investigation is approved or funded by at least one of the following:
        - The National Institutes of Health.
        - The Centers for Disease Control and Prevention.
        - The Agency for Health Care Research and Quality.
        - The Centers for Medicare & Medicaid Services.
        - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.

- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
  * It is comparable to the National Institutes of Health system of peer review of studies and investigations.
  * It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

Please see *Chapter 4: Services Not Covered for exclusions*.

Chapter 4: Services Not Covered

About this Chapter

Your health care coverage does not provide benefits for Services or supplies that are listed in this chapter or limited by this chapter or *Chapter 3: Benefit Description*. We divided this chapter with category headings to help you find what you are looking for.

Please note: Even if a Service or supply is not specifically listed as an exclusion in this chapter, there are additional exclusions as described as limitations in *Chapter 3: Benefit Description*. If a Service or supply does not meet the criteria described in *Chapter 3: Benefit Description*, then it should be considered an exclusion and is not covered. This chapter should be read in conjunction with *Chapter 3: Benefit Description* in order to identify all items that are excluded from coverage. If that Service or supply is not specifically listed as an exclusion in this chapter or as a limitation exclusion in *Chapter 3*, it will not be covered unless it is described in *Chapter 3: Benefit Description*, meets all of the criteria, circumstances or conditions described in *Chapter 3: Benefit Description*, and meets all of the criteria described in *Chapter 1: Important Information* under *Questions We Ask When You Receive Care.*

Service means any treatment, diagnosis, care, procedure, test, drug, injectable, facility, equipment, item, device, or supply. When a Service is excluded, exhausted, or not covered, all Services that are necessary or related to the excluded, exhausted or non-covered Service are also not covered.

Your plan may include additional benefits (called Riders) that may override some of these exclusions. Please refer to the *Benefit Summary* section in the front of this Guide.

If you are unsure if a specific Service or supply is covered or not covered, please call Member Services, and we will help you. We list our telephone numbers in the back of this Guide.

Counseling Services

Genetic Counseling: You are not covered for genetic counseling, except as identified on the U.S. Preventive Services Task Force list of Grade A and B recommendations. If you need more information about USPSTF recommended counseling, including a current list of recommendations, please visit our website at www.kp.org or call Member Services at the phone number listed in the back of this Guide.

Marriage or Family Counseling: You are not covered for marriage and family counseling or other similar Services.

Dental, Drug, Hearing Aids and Vision

Dental Care: You are not covered for dental care Services. The following exclusions apply regardless of the symptoms or illnesses being treated:

- Orthodontics.
- Dental implants.
- Dental x-rays.
- Dental splints and other dental appliances.
- Dental prostheses, devices and appliances.
- Maxillary and mandibular implants (osseointegration) and all related Services.
- Removal of impacted teeth.
- Any other dental procedures involving the teeth, gums and structures supporting the teeth.
- Any Services in connection with the treatment of TMJ (temporomandibular joint), Craniomandibular Pain Syndrome (CPS) problems or malocclusion of the teeth or jaws, except for limited medical Services related to the initial diagnosis for TMJ or malocclusion.

The following only applies to Non-Grandfathered plans: Qualified health plans (QHPs) bundled with an exchange-certified stand-alone dental plan (with "Dental" in the plan name) include coverage of pediatric dental services provided by Hawaii Dental Service (HDS). Information regarding dental benefits should be obtained directly from HDS.

Drugs and related items: You are not covered for:

- Drugs and supplies except as stated in *Chapter 3: Benefit Description* under *Prescription Drugs* and as identified on the U.S. Preventive Services Task Force list of Grade A and B recommendations.
- Replacement for lost, stolen, damaged, or destroyed drugs and supplies.
- Self-administered drugs, except when required by state or federal law, as described in the *Benefit Summary* Prescription Drug section in the front of this Guide and *Chapter 3: Benefit Description*.
- Drugs for which a prescription is not required by law including condoms, contraceptive foams, creams or other nonprescription substances used individually or in conjunction with any other prescribed drug or device, except insulin. This exclusion does not apply to tobacco cessation drugs and products as described in the *Benefit Summary* section in the front of this Guide and *Chapter 3: Benefit Description*.
- 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.
- Prescribed drugs or diabetes supplies that are necessary or associated with Services excluded or not covered.

- Drugs or diabetes supplies not included in the Health Plan formulary, unless a non-formulary drug or diabetes supply has been specifically prescribed and authorized by the licensed Prescriber.
- Drugs to shorten the duration of the common cold.
- Drugs related to enhancing athletic performance (including weight training and body building).
- Any packaging other than the dispensing pharmacy's standard packaging.
- Replacement of lost, stolen or damaged drugs or devices

Eyeglasses and Contacts: You are not covered for:

- Vision therapy, including orthoptics, visual training and eye exercises.
- Sunglasses.
- Prescription inserts for diving masks or other protective eyewear.
- Nonprescription industrial safety goggles.
- Nonstandard items for lenses including tinting and blending.
- Oversized lenses, and invisible bifocals or trifocals.
- Repair and replacement of frame parts and accessories.
- Eyeglasses and contact lenses.
- Exams for a fitting or prescription (including vision exercises).
- Frames.

Hearing Aids: You are not covered for all hearing aids and all other related costs, except as described in *Chapter 3: Benefit Description* under *Hearing Aids*, including but not limited to:

- Consultation
- Fitting
- Rechecks
- Adjustments

Vision Services: You are not covered for:

- Refractive eye surgery to correct visual acuity problems.
- Replacement of lost, stolen or broken lenses, contact lenses or frames.
- Vision training. Reading problem studies or other procedures determined to be special or unusual.
- Eye surgery solely for the purpose of correcting refractive error of the eye, such as Photo-refractive Keratectomy (PRK), lasek eye surgery, and lasik eye surgery.

Fertility and Infertility

Contraceptives: You are not covered for contraceptives except as described in the *Benefit Summary* section in the front of this Guide and *Chapter 3: Benefit Description* under *Prescription Drugs*.

Infertility Treatment: Except as described in *Chapter 3: Benefit Description* under *Special Services for Women*, you are not covered for Services or supplies related to the treatment of infertility, including but not limited to:

- Collection, storage and processing of sperm.
- Cryopreservation of oocytes, sperm and embryos.
- In vitro fertilization using Services of a Surrogate.
- In Vitro fertilization using donor oocytes.
- Cost of donor oocytes and donor sperm.
- Any donor-related Services, including but not limited to collection, storage and processing of donor oocytes and donor sperm.
- Artificial Insemination, except as described in *Chapter 3: Benefit Description* under *Special Services for Women.*
- Ovum transplants.
- Gamete intrafallopian transfer (GIFT).
- Zygote intrafallopian transfer (ZIFT).
- Stand-alone ovulation induction drugs and Services.
- Services related to conception by artificial means including drugs and supplies related to such Services except as described in *Chapter 3: Benefit Description* under *Special Services for Women*.

Sterilization Reversal: You are not covered for the reversal of a voluntary, surgically induced infertility such as vasectomy or tubal ligation.

Transplants

Living Organ Donor Services: You are not covered for organ door Services if you are the organ donor.

Living Donor Transport: You are not covered for expenses of transporting a living donor.

Mechanical or Non-Human Organs: You are not covered for transplant services or supplies or related Services or supplies other than those described in *Chapter 3: Benefit Description* under *Transplant Services for Transplant Recipients*.

Transplant Services for Transplant Donors: You are not covered for non-human and artificial organs and their implantation; and bone marrow transplants associated with high dose chemotherapy for solid tissue tumors, except for germ cell tumors and neuroblastoma in children.

Miscellaneous Exclusions

Acupuncture: You are not covered for Services or supplies related to acupuncture, unless your plan includes an acupuncture rider which would be reflected in the *Benefit Summary* section of this Guide.

Alternative Medical Services: You are not covered for alternative medical Services not accepted by standard allopathic medical practices such as: hypnotherapy, behavior testing, sleep therapy, massage therapy, naturopathy, rest cure and aroma therapy.

Note: This exclusion does not apply to alternative medical Services that are accepted by standard allopathic medical practices and meet the requirements of medical necessity, as described in *Chapter 1: Important Information*.

Artificial Aids and Corrective Appliances: You are not covered for artificial aids and corrective appliances, such as orthopedic aids and corrective lenses and eyeglasses, except that:

- Physicians provide the professional services necessary to determine the need therefore and attempt to make arrangements whereby they may be obtained,
- external prosthetic devices and braces are provided in accord with the *Benefit Summary* and *Chapter 3: Benefit Description* in this Guide, and
- hearing aids are provided in accord with the *Benefit Summary* and *Chapter 3: Benefit Description* in this Guide.

Airline Oxygen: You are not covered for airline oxygen.

Autism Services: You are not covered for Services provided by family or household members, and for autism Services that duplicate Services provided by another therapy or available through schools and/or government programs.

Braces: You are not covered for the following:

- Dental prostheses, devices and appliances;
- Non-rigid appliances such as elastic stockings, garter belts, arch supports, non-rigid corsets and similar devices;
- Pacemakers and other surgically implanted internal prosthetic devices;
- Hearing aids;
- Corrective lenses and eyeglasses;
- Orthopedic aids such as corrective shoes and shoe inserts;
- Replacement of lost prosthetic devices;
- Repairs, adjustments or replacements due to misuse or loss;
- Experimental or research devices and appliances;
- External prosthetic devices related to sexual dysfunction;
- Supplies, whether or not related to external prosthetic devices or braces;
- External prosthetics for comfort and/or convenience, or which are not medical in nature; and
- Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages.

Biofeedback: You are not covered for biofeedback and any related diagnostic tests.

Blood and Blood Processing: You are not covered for all blood, blood products, blood derivatives, blood components and donor directed units whether of human or manufactured origin and regardless of the means of administration, except as described in *Chapter 3: Benefit Description*.

Certain Examinations and Services: You are not covered for Services and related reports/paperwork, in connection with third party requests or requirements, such as those for: employment, participation in employee programs, sports, camp, insurance, disability, licensing, or on court order or for parole or probation.

Note: Physical examinations that are authorized and deemed Medically Necessary by a Physician and are coincidentally needed by a third party are covered.

Chemotherapy (High Dose): You are not covered for bone marrow transplants associated with high dose chemotherapy for solid tissue tumors.

Chiropractic Services: You are not covered for Services of chiropractors or chiropractic Services, unless your plan includes a chiropractic rider which would be reflected in the *Benefit Summary* section of this Guide.

Clinical Trials (applies to Grandfathered plans)**:** You are not covered for clinical trials or related Services. If two or more Services are part of the same plan treatment or diagnosis, all of the Services are excluded if one of the Services is a clinical trial.
Note: We will cover Services that would be covered if you were not participating in a clinical trial.

Clinical Trials (applies to Non-Grandfathered plans)**:**
You are not covered for:

- the investigational service or item itself that is part of a covered clinical trial,
- for Services provided solely for data collection and analysis,
- Services that are not used in the direct clinical management of the patient, and
- Services that are clearly inconsistent with widely accepted established standards of care for a particular diagnosis.

Complications of a Non-Covered Procedure: You are not covered for complications of a non-covered procedure, including complications of recent or past cosmetic surgeries, Services or supplies.

Note: This exclusion does not apply to treatment for complications resulting from cosmetic Services performed by a Physician in a KP facility while you were a Kaiser Permanente Hawaii Member.

Confined Members: You are not covered for Services provided or arranged by criminal justice institutions for Members confined therein, unless the Services would be covered as Emergency Services.

Convenience Services or Supplies: You are not covered for Services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience, or the comfort or convenience of

your provider or caregiver. Such items may include ramps, home remodeling, hot tubs, swimming pools, deluxe/upgraded items, or personal supplies such as surgical stockings and disposable underpads.

Cosmetic Services: You are not covered for cosmetic Services, plastic surgery or other Services that are indicated primarily to change or maintain your appearance and are not likely to result in significant improvement in physical function, including treatment for complications resulting from cosmetic Services.

Note: This exclusion does not apply to procedures that (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; (b) are incident to a covered mastectomy; or (c) treatment for complications resulting from cosmetic Services provided by a Physician in a KP facility.

Custodial Care: You are not covered for custodial care. Custodial care is routine nursing Services and assistance with activities of daily living such as personal hygiene, help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. Also excluded is care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.

Dependent Child Outside of Service Area Benefit: Your Dependent Child who is outside of the Service Area, is not covered for the following:

- Transplant Services and related care;
- Services received outside the United States (the 50 states, Guam and Puerto Rico);
- Services other than routine primary care, basic laboratory, basic imaging, testing, and self-administered prescription drugs;
- Outpatient surgery and procedures performed in an ambulatory surgery center or other hospital-based setting;
- Services received in other Kaiser regions' service areas;
- Services received within the Service Area;
- Dental Services;
- Mail order drugs;
- Chiropractic, acupuncture and massage therapy Services;
- Services not explicitly listed in the *Dependent Child Coverage Outside the Service Area* section in Chapter 3: Benefit Description; and
- All other exclusions listed in this chapter.

Developmental Delay: You are not covered for treatment of developmental delay or Services related to developmental delay that are available through government programs or agencies.

Duplicate Item: You are not covered for duplicate durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that are intended to be used as a back-up device, for multiple residences, or for traveling, e.g., a second wheeled mobility device specifically for work or school use or a back-up manual wheelchair when a power wheelchair is the primary means of mobility.

Durable Medical Equipment: You are not covered for durable medical equipment, such as oxygen dispensing equipment, hospital beds, and wheelchairs used in the Member's home (including an institution used as his or her home), except as provided in accord with the Benefit Summary and Chapter 3: Benefit Description in this Guide for Members on a Non-Grandfathered plan; and except that diabetes and home phototherapy equipment is provided as described in Chapter 3: Benefit Description for all Members.

You are not covered for comfort and convenience equipment, disposable supplies, and devices not medical in nature such as:

- Sauna baths and elevators
- Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages
- Exercise and hygiene equipment
- Electronic monitors of the function of the heart or lungs
- Devices to perform medical tests on blood or other body substances or excretions
- Dental appliances or devices
- Repair, adjustment or replacement due to misuse of loss
- Experimental or research equipment
- Durable medical equipment related to sexual dysfunction, and
- Modifications to a home or car

Effective Date: You are not covered for Services or supplies that you get before the effective date of this coverage.

Erectile Dysfunction: Refer to Sexual Dysfunction.

Experimental Services: You are not covered for a Service that is experimental or investigational for your condition if, at the time the Service is or will be provided to you, the Service is provided pursuant to informed consent documents that describe the Service as experimental or investigational, or pursuant to any other written protocol, disclosure form or other similar document that describes the Service as experimental or investigational. If two or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

False Statements: You are not covered for Services and supplies if you are eligible for care only by reason of a fraudulent statement or other intentional misrepresentation that you made on an application or enrollment form for membership or in any claims for benefits. If we pay benefits to you or your provider before learning of any false statement, you are responsible for reimbursing us.

Foot Care: You are not covered for routine foot care that is not Medically Necessary.

Foot Orthotics: You are not covered for foot orthotics.

Genetic Testing and Screening: You are not covered for genetic tests and screening except as stated in *Chapter 3: Benefit Description* under Laboratory, Imaging and Testing and Routine and Preventive Services.

Growth Hormone Therapy: You are not covered for growth hormone therapy except as stated in *Chapter 3: Benefit Description*.

Hair Loss: You are not covered for Services or supplies, related to the treatment of baldness or hair loss regardless of condition. This includes hair transplants and topical medications.

Health Education: You are not covered for specialized health promotion classes and support groups (such as weight management and bariatric surgery program).

Home Health Care: Your home health Services do not include custodial care, homemaker care, or care that the Medical Group home health committee determines may be appropriately provided in the medical office, hospital or skilled nursing facility.

Immunizations: You are not covered for travel immunizations.

Informed Consent Protocols: You are not covered for a Service that at the time the Service is or will be provided to the Member, is provided pursuant to informed consent documents, written disclosure form, or other written protocols that indicate that the Service is being evaluated for its safety, toxicity, or efficacy. If two or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is provided pursuant to such informed consent documents.

Intermediate Care: You are not covered for care or Services in an intermediate care facility or Services for which, in the judgment of the Physician, the facilities and Services of an acute general hospital or the extended care Services of a Skilled Nursing Facility are not Medically Necessary.

Investigational Services: Refer to Experimental Services.

Massage Therapy: You are not covered for massage therapy Services.

Medical Services/care or items for which coverage has been exhausted or are excluded: You are not covered for Medical Services/care or items for which coverage has been exhausted, or are excluded**.**

Motor Vehicles: You are not covered for the cost to buy or rent motor vehicles such as cars and vans. You are also not covered for equipment and costs related to converting a motor vehicle to accommodate a disability.

Non-Medical Items: You are not covered for durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances that are not primarily medical in nature, e.g., environmental control equipment or supplies (such as air conditioners, humidifiers, dehumidifiers, air purifiers or sterilizers, water purifiers, vacuum cleaners, or supplies such as filters, vacuum cleaner bags and dust mite covers); hygienic equipment; exercise equipment; items primarily for participation in sports or leisure activities, and educational equipment.

No FDA Approval: You are not covered for a Service that at the time the Service is or will be provided to you, cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted, or is the subject of a current new drug or new device application on file with the FDA and such approval has not been granted. If two or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services has not received FDA approval. This is not intended to exclude off-label uses of drugs which have received FDA approval for another use.

Private Duty Nursing: You are not covered for private duty nursing Services.

Physical Examinations: You are not covered for physical or health exams and any associated screening procedures except as described in *Chapter 3: Benefit Description* under the Routine and Preventive section.

Physical, Occupational and Speech Therapy: You are not covered for:

- Maintenance therapy;
- Long-term physical, occupational and speech therapy;
- Unskilled therapy; and
- Physical, occupational, and speech therapy deficits due to developmental delay.

Related Items Exclusion: You are not covered for any Service or supply that is directly or indirectly related to an excluded or exhausted Service.

Repair/Replacement: You are not covered for the repair or replacement of durable medical equipment and supplies, orthotics and external prosthetics, and vision and hearing appliances covered under the manufacturer or supplier warranty or that meet the same medical need as the current item but in a more efficient manner or is more convenient, when there is no change in your medical condition.

Self-Health or Self-Cure: You are not covered for self-help and self-cure programs or equipment.

Services Related to Employment: You are not covered for Services related to obtaining or maintaining employment.

Sexual Dysfunction: You are not covered for drugs, injections, equipment, supplies, prosthetics, devices and aids related to treatment of sexual dysfunction.

Services Not Generally and Customarily Available: You are not covered for any Service not generally and customarily available in the Service Area unless it is generally accepted medical practice to refer patients outside the Service Area for such Service.

Services Subject to Institutional Review Board or Other Body: You are not covered for any Service that at the time the Service is or will be provided to you, is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of Services. If two or more Services are part of the same plan of treatment or

diagnosis, all of the Services are excluded if one of the Services is subject to approval or review by the IRB or such other body.

Take home supplies: You are not covered for supplies for home use such as bandages, gauze, tape, antiseptics, and ace-type bandages.

Transportation, Lodging, or Living Expenses: You are not covered for transportation (other than covered ambulance Services described in *Chapter 3: Benefit Description*), lodging and living expenses.

Vitamins, Minerals, Medical Foods and Food Supplements: You are not covered for vitamins, minerals, medical foods or food supplements except as described in *Chapter 3: Benefit Description* under Miscellaneous Medical Treatments.

Weight Program Management: You are not covered for weight reduction programs and supplies, whether or not weight reduction is medically appropriate. This includes dietary supplements, food, equipment, lab tests, and drugs and supplies.

Wigs: You are not covered for wigs and artificial hairpieces.

In addition to the exclusions in this Chapter, the following plans listed also exclude:

Kaiser Permanente Diamond Plan, Kaiser Permanente Platinum Plan, Kaiser Permanente Gold Plan, Kaiser Permanente Silver Plan: These 4 Grandfathered plans exclude: Obstetrical/maternity Services (such as prenatal care, delivery, and post-partum care); durable medical equipment; external prosthetics and orthotics; and hearing aids.

Kaiser Permanente Silver Plan (a Grandfathered Plan): Self-administered drugs (except when required by state or federal law); observation Services; outpatient lab, imaging and testing; outpatient surgery and procedures; outpatient radiation therapy and chemotherapy; blood or internal prosthetics in an outpatient setting; skilled administered drugs (except when required by law); outpatient dialysis; infertility Services; family planning Services; physical, occupational, and speech therapy; transplant services; abortions and sterilizations performed in the Medical Office; behavioral health (mental health, chemical dependency) residential Services; chemical dependency specialized facility Services; and house calls.

This plans also excludes coverage for all office visits except:

- Well child office visits (at Member's birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, and 5 years), which are provided without charge.
- One preventive care office visit per calendar year (for Members 6 years of age and over) or one gynecological office visit per calendar year for female Members is provided without charge.
- Office visits for diabetes self-management training and education are provided upon payment of $30.00 per visit.
- Office visits for treatment of physical complications of all stages of mastectomy, including lymphedemas, are provided upon payment of $30.00 per visit.

- Routine pre-surgical and post-surgical office visits, in connection with a covered surgery, are provided without charge.
- Office visits for autism care are provided upon payment of $30.00 per visit.
- Office visits for orthodontic care for the treatment of orofacial anomalies (from birth), are provided upon payment of $30.00 per visit.
- Office visits required to be covered under federal or Hawaii state law are provided upon payment of $30.00 per visit.

Limitations

The rights of Members and obligations of Health Plan, Hospitals, Medical Group and Physicians under this EOC are subject to the following limitations.

Unusual Circumstances

If, due to unusual circumstances, such as (a) complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes not involving Health Plan, Hospitals or Medical Group, major disaster, disability of a significant part of Hospital or Medical Group personnel, epidemic, or similar causes, or (b) labor disputes involving Health Plan, Hospitals or Medical Group, the rendition or provision of professional services and other benefits covered under this EOC are delayed or rendered impractical, Hospitals, Medical Group and Plan providers will, within the limitation of available facilities and personnel, use their best efforts to provide professional services and other benefits covered under this EOC, but, with regard to (a), neither Health Plan, Hospitals, Medical Group nor any Physician shall have any liability or obligation on account of such delay or such failure to provide professional services or other benefits, and with regard to (b), the provision of non-emergent care may be deferred until after resolution of the labor dispute.

Surrogacy Arrangements: Traditional and Gestational Carriers

A “Surrogacy Arrangement”, whether traditional or gestational is one in which a woman (“Surrogate”) agrees (orally or by written agreement) to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Services a Surrogate receives related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement are called "Surrogacy Health Services". Surrogacy Health Services are covered under this Guide to the extent of surrogacy conception, pregnancy and delivery of a baby. However, you must reimburse us for the costs of Surrogacy Health Services, out of the compensation you or your payee are entitled to receive under the Surrogacy Arrangement.

By accepting Surrogacy Health Services, you automatically assign to us their right to receive payments that are payable to you or to your payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of compensation you or your payee is entitled to receive under the Surrogacy Arrangement.

Within 30 days after entering into a Surrogacy Arrangement, you must send us written notice of the Surrogacy Arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

Equian
Kaiser Permanente - Hawaii Region
Surrogacy Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: 1-502-214-1137

You must complete and send to us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine and protect any rights we may have under this "Surrogacy Arrangement" section. You must not take any action prejudicial to our rights. If your estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator, and any settlement or judgment recovered by the estate, parent, guardian, or conservator, shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party, as described in the Third-Party Liability section of this guide.

Chapter 5: Wellness and Other Special Features

- Extra Services
- Healthy Living
- My Health Manager
- Total Health Assessments

Extra Services

In addition to the medical services and other benefits specified in this EOC, we also make available to you a variety of extra services that are not covered as benefits under this EOC. Examples may include:

- certain non-covered health education classes and publications
- discounts for fitness club memberships
- health promotion and wellness programs
- rewards for participating in those programs.

If your plan includes extra services, details concerning the offer of these extra services will be described in a separate document.

Such extra services may be provided by vendors other than us, and they are neither offered nor guaranteed under any health care coverage contract of ours. We or these vendors may change or discontinue some or all of these services at any time. These extra services are not offered as an inducement to purchase health care coverage from us.

Healthy Living

When available, specialized healthy living classes and resources are provided upon payment of reasonable class fees. Healthy living classes and resources include educational programs and support groups to help you make changes to reduce health risks, enhance the quality of your life, or maintain your level of health. For information on our special healthy living classes please visit our website at www.kp.org or call Member Services at the phone number listed in the back of this Guide.

We support your total well-being, mind, body and spirit with classes that include topics such as:

- Cancer
- Child and Teen Health
- Chronic Condition Self-Management
- Diabetes

- Exercise and Fitness
- Heart and Circulatory Health
- Mental Health and Social Well-Being
- Nutrition
- Physical Therapy
- Pregnancy and Childbirth
- Smoking and Tobacco Cessation
- Weight Management
- Women's Health
- Self-Care Programs and Support Groups
- Senior Healthy and Aging

My Health Manager (www.kp.org)

We provide multiple methods for you to access medical care conveniently when you need us anytime, anywhere. You can visit us online at www.kp.org, through a computer or mobile device, where you can schedule, view, or cancel routine appointments; email your doctor's office; refill a prescription; review your medical record and most test results; and much more.

Total Health Assessment

Total Health Assessments are available for you and your covered dependents age 18 and older. Total Health Assessment is our free online healthy lifestyle program* that evaluates your health and lifestyle. This assessment helps you design a customized well-being plan that fosters healthy behavior to prevent health problems and help you feel your very best. You can visit us at www.kp.org to start your Total Health Assessment today.

*Programs are offered in collaboration with Johnson & Johnson Health and Wellness Solutions, Inc.

Chapter 6: Membership Information

- Eligibility
- Enrollment
- Effective Date of Coverage
- When Eligibility for Coverage Ends
- Continuation of Coverage and Change of Residence
- Member Termination Provisions

Eligibility

Individuals are accepted for enrollment and may continue coverage hereunder only if they meet all applicable requirements set forth in this EOC.

Subscribers (on a Grandfathered Plan)

Our Grandfathered individual plans are closed for enrollment of new Subscribers.

For continued enrollment, a Subscriber must meet the following criteria:

- Lives within our Service Area,
- does not have other health coverage,
- has timely paid the applicable Monthly Premiums, and
- is not entitled to Medicare Part A or enrolled in Part B.

Subscribers (on a Non-Grandfathered plan)

To be eligible to enroll and to remain enrolled as a Subscriber, you must meet all the of the following requirements:

- You enroll during an annual open enrollment period or special enrollment period, as described under “Annual Open Enrollment Period” and “Special Enrollment Period” in this Chapter,
- live within our Service Area,
- have submitted a completed enrollment application,
- have paid the applicable Monthly Premiums prior to the initial effective date of coverage, and
- are not entitled to Medicare Part A or enrolled in Part B.

Family Dependents

In addition to meeting the same requirements as the Subscriber, the individuals defined below are eligible to enroll as the Subscriber’s Family Dependents under this EOC.

To be an eligible Family Dependent, a person must live within our Service Area (except for dependents under age 26), not be eligible for or entitled to coverage under Medicare (such as Parts A and/or B),

have paid the applicable Monthly Premiums prior to the effective date of coverage, and is one of the following:

- The Subscriber's Spouse; or
- A dependent (biological, step, Foster or adopted) child of the Subscriber or the Subscriber's Spouse and either:
    - Under age 26; or
    - Over age 26 and incapable of self-sustaining employment because of physically- or mentally-disabling injury, illness, or condition that occurred prior to reaching age 26, and receive 50 percent or more of their support and maintenance from the Subscriber or the Subscriber's Spouse, with proof of incapacity and dependency furnished annually if requested by Health Plan; or
- Any other dependent person under age 26 for whom the Subscriber or Subscriber's Spouse is (or was before the person's 18th birthday) the court appointed legal guardian, or
- A child who is the subject of a petition for adoption filed in the appropriate court by Subscriber who is seeking adoption of the child.

Notes:
If the Subscriber is no longer eligible for continued enrollment hereunder, the Subscriber's Family Dependents are not eligible for continued enrollment.

Health plan may perform periodic audits to confirm dependent status.

Persons Not Eligible for Membership

- Any person or any other person in his or her Family Unit who has had his or her membership terminated for cause or for nonpayment as stated in the *Member Termination Provisions* section of this Chapter in this EOC, except where prohibited by applicable law.
- Individuals or any other person in his or her family (except for dependents under age 26) living outside the Service Area.
- Persons who are eligible for or entitled to coverage under Medicare (such as Parts A and/or B). If a person is entitled to Medicare, please contact Member Services at the phone number in the back of this Guide, for information about our Senior Advantage Plan.
- Persons who have other health coverage

Enrollment

Newborn Children

You may enroll your eligible newborn child as your Family Dependent. To do this, you must submit a completed account change form to us no later than 31 calendar days after the child's birth if on a Grandfathered Plan (no later than 60 calendar days after the child's birth if on a Non-Grandfathered Plan). If you do not, you have the option to apply for one of our ACA individual plans during the individual plan annual open enrollment period.

Newborns Adopted by the Subscriber and/or Spouse

You may enroll your eligible adopted newborn as your Family Dependent.

- If the eligible newborn who is adopted by you and/or your Spouse, or placed for adoption with you and/or your Spouse, has been treated from birth by a Kaiser Permanente Hawaii physician, you must give us written notice of your intent to adopt and also a completed account change form within 31 calendar days of birth of the newborn if on a Grandfathered Plan (within 60 calendar days of birth if on a Non-Grandfathered Plan).
- If the eligible newborn who is adopted by you and/or your Spouse, or placed for adoption with you and/or your Spouse, has not been treated from birth by a Kaiser Permanente Hawaii Physician, you must submit to us a completed account change form within 31 calendar days of birth if on a Grandfathered Plan (within 60 calendar days of birth if on a Non-Grandfathered Plan), and also provide one of the following: 1) a copy of the court order of adoption or proof that the child has been placed for adoption with you and/or your Spouse, or 2) a document authorizing you and/or your Spouse to consent to treatment for the newborn.

If we fail to receive these documents from you within 31 calendar days of the child's birth (or the child being placed for adoption) for a Grandfathered Plan (60 calendar days for a Non-Grandfathered Plan), you have the option to apply for one of our ACA individual plans during the individual annual open enrollment period.

Children (one month of age or older) Adopted by the Subscriber or Spouse

You may enroll your eligible adopted child as your Family Dependent. The eligible child must be the subject of a petition for adoption or placement for adoption with you and/or your Spouse. You must submit to us a completed account change form within 31 calendar days of adoption or placement for adoption if on a Grandfathered Plan (60 calendar days if on a Non-Grandfathered Plan), and also provide one of the following: 1) a copy of the court order or other proof showing the child has been adopted or placed for adoption with you and/or your Spouse, or 2) a document authorizing you and/or your Spouse to consent to treatment for the child.

If we fail to receive these documents from you within 31 calendar days of the petition for adoption being filed in court if you are on a Grandfathered Plan (60 calendar days if you are on a Non-Grandfathered Plan), you have the option to apply for one of our ACA individual plans during the individual annual open enrollment.

Spouse

A Spouse must meet our current requirements for membership. You must submit a completed account change from within 31 calendar days of your Spouse becoming newly eligible (e.g. – being married) if on a Grandfathered Plan (60 calendar days if on a Non-Grandfathered Plan). If you do not submit an account change form within 31 calendar days for a Grandfathered Plan (60 calendar days for a Non-Grandfathered Plan), you have the option to apply for one or our ACA individual plans during the individual annual open enrollment.

All Other Family Dependents

All other eligible Family Dependents must meet our current requirements for membership. You must submit a completed account change form within 31 calendar days of the Family Dependent becoming newly eligible if on a Grandfathered Plan (60 calendar days if on a Non-Grandfathered Plan). If you do not submit a change or enrollment form within 31 calendar days for a Grandfathered Plan (60 calendar days for a Non-Grandfathered Plan), you have the option to apply for one or our ACA individual plans during the individual annual open enrollment.

Annual Open Enrollment Period

You may only apply for health care coverage or change enrollment from this plan to another plan during the annual open enrolment period as specified by law.

For Members on a Non-Grandfathered ACA plan, outside of this annual open enrollment period, you may enroll or change your coverage if you experience a situation known as a qualifying life event (such as birth, adoption, marriage). Refer to the "Special enrollment period" section of this EOC for further information.

Special Enrollment Period (Enrollment of Family Dependents Outside of the Annual Enrollment Period - for Members on a Non-Grandfathered plan)

You or your Family Dependent may experience a qualifying life event that allows a change in your enrollment. Examples of qualifying life events are the loss of coverage, marriage, and birth of a child. The qualifying life event results in a special enrollment period that usually (but not always) starts on the date of the qualifying life event and lasts for 60 days. During the special enrollment period, you may enroll your Family Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Family Dependent's qualifying life event.

For a complete list of qualifying life events and the related effective dates of coverage, please refer to our special enrollment guide. You can obtain a copy by calling our Member Services at the phone number in the back of this Guide, or by visiting kp.org/specialenrollment.

Effective Date of Coverage

Newly Eligible Persons (on a Grandfathered Plan)

Coverage for every newly eligible and enrolled person, except a newborn child as described below, is effective on the first day of the month following the date we receive the enrollment form from Subscriber as specified in the *Enrollment* section in this chapter.

- An eligible newborn child of a Subscriber is covered from birth in accord with this EOC if enrolled within 31 calendar days after birth. Newborns who receive medical services from non-Physicians will only be covered for Emergency Services in accord with the *Emergency Services* section in *Chapter 3: Benefit Description* in this Guide.

- A newborn who is the subject of a petition for adoption by Subscriber and who has been treated from birth by a Physician is covered from birth if:
    - Subscriber gives Health Plan written notice of Subscriber's intent to adopt the newborn prior to birth or within 31 calendar days of birth of the newborn, and
    - The newborn is enrolled in accord with the *Enrollment* section in this chapter.
- A newborn or child who is the subject of a petition for adoption by Subscriber and who has not been treated from birth by a Physician is covered from the earlier of:
    - the first calendar day following receipt by Health Plan, of a document authorizing Subscriber to consent to treatment for the child, and a properly completed enrollment form, or
    - the date the child is placed for adoption with Subscriber, if Health Plan receives written notification of the placement within 31 calendar days of the placement. Placement occurs when Subscriber assumes legal obligation for total or partial support of the child in anticipation of the adoption.

Newly Eligible Persons (on a Non-Grandfathered ACA Plan)

During an individual plan annual open enrollment period:

- An individual may apply for enrollment as a Subscriber, and may also apply to enroll eligible Family Dependents, by submitting an application form to our Federally Facilitated Marketplace via Healthcare.gov during the annual open enrollment period. If our Federally Facilitated Marketplace accepts the application, they will notify the individual of the date coverage begins. Membership begins at 12 a.m. (Hawaii Standard Time) of the effective date specified in the notice.

During a special enrollment period:

- For a complete list of special enrollment qualifying life events and the related effective dates of coverage, please refer to our special enrollment guide.
- You can obtain a copy by calling our Member Services at the phone number in the back of this Guide, or by visiting kp.org/specialenrollment.

Note: Family Dependents may not have an earlier effective date than the Subscriber's effective date.

When Eligibility for Coverage Ends

Subject to continuing eligibility as specified in the *Eligibility* section of this chapter, coverage continues from month to month subject to prepayment of applicable Monthly Premiums. Eligibility for coverage will terminate on the last day of the month in which any of the following events take place:

- You fail to meet the eligibility criteria specified in this EOC,
- For the divorced spouse of Subscriber (or surviving spouse of a deceased Subscriber), the month in which the divorce becomes final, or Subscriber dies.

If you have purchased your plan through the marketplace exchange, you may terminate your membership online at healthcare.gov. Membership will terminate on the last day of the month of your request, or sooner if required by applicable law.

If you have not purchased your plan through the marketplace exchange, you may terminate membership for yourself and your Family Dependent(s), or for any particular Family Dependent, to the extent permitted by applicable law, including when a Member obtains another health plan with minimum essential coverage. You must give us at least 30 calendar days prior written notice. Membership will terminate on the last day of the month of your request, or sooner if required by applicable law.

For a Family Dependent child, membership ends on the last day of the calendar year in which the child reaches age 26, or membership ends on the last day of the month in which the child no longer meets all of the other requirements of this EOC for Family Dependent status.

When eligibility ends for an individual as described above, Health Plan will send notice to the Subscriber or Family Dependent, as applicable, that membership is terminating due to loss of eligibility, no less than 30 days prior to the last day of coverage. The last day of coverage is the last day of the month following the month that notice of ineligibility is sent to the Subscriber or Family Dependent. The Subscriber or Family Dependent may request an earlier termination than set forth in this paragraph, if desired.

Note: If the Subscriber is no longer eligible for continued enrollment (has membership terminated), the Subscriber's Family Dependents are not eligible for continued enrollment beyond the Subscriber's termination date.

Continuation of Coverage and Change of Residence

Continuation of Coverage

A Family Dependent residing in the Service Area who loses coverage due to loss of eligibility may continue Health Plan membership with no break in coverage by enrolling in certain Kaiser Permanente for Individuals and Families Plans if the Family Dependent meets the eligibility criteria of that plan. However, the Family Dependent must complete, sign and submit to Health Plan the applicable enrollment form as a Subscriber on that plan.

Subscriber membership begins when:

1) Family Dependent membership ends, and
2) a timely submitted and signed enrollment form has been accepted by Health Plan, and
3) Subscriber has prepaid the applicable Monthly Premiums required for membership.

The Family Dependent must apply to us to be a Subscriber on that plan within 31 calendar days if on a Grandfathered plan (60 calendar days if on a Non-Grandfathered plan) after ceasing to qualify as a Family Dependent under this EOC. To continue with Grandfathered coverage, you must apply before your termination effective date.

If a Family Dependent does not continue membership by the conversion procedure described above, the Family Dependent has no rights to benefits under this EOC, and will be responsible for full charges for any services received by the Family Dependent after losing eligibility.

Continuation of coverage is not permitted for a Subscriber or Family Dependents (except for dependents under age 26) residing outside of the Service Area, nor for a person whose membership we terminate for a reason stated in the *Member Termination Provisions* section of this Chapter.

Note: After the 31 calendar day period if on a Grandfathered plan (60 calendar day period if on a Non-Grandfathered ACA plan), Family Dependents have the option to apply for one of our Affordable Care Act ("ACA") individual plans during an individual annual open enrollment or special enrollment period. All plans have specific eligibility and enrollment criteria that must be met.

Change of Residence – General

We may terminate the membership of any Member (except Family Dependents under age 26) who move outside the Service Area, in accord with the *Member Termination Provisions* section of this chapter. Subscriber must provide immediate written notice to us regarding any Member who moves outside of the Service Area. The only benefits covered by this Guide outside the Service Area prior to termination of membership are Emergency and Urgent Care Services specified in the Emergency Services and Urgent Care sections in *Chapter 3: Benefit Description* in this Guide. Members who move to another Kaiser service area can contact the Member Services department in that service area to apply for membership there.

Member Termination Provisions

When Health Plan terminates your membership, neither Health Plan, Hospitals, Medical Group, nor any Kaiser Permanente provider has any further liability or responsibility under this EOC, for any Services obtained after the Member's termination date. All rights to medical services and other benefits under this EOC end at 11:59 PM on the termination date specified by us.

Any termination of Subscriber's membership for any of the reasons in this *Member Termination Provisions* section will also terminate the membership of all Family Dependents, as of the same termination date as the Subscriber. Termination of membership terminates all coverage rights under this EOC. Services received after the termination date will not be covered and the Members will be responsible for all charges.

Members may not enroll in any Kaiser Permanente plan if membership is terminated for non-payment (subject to the provisions listed in the *"Termination for Nonpayment"* section in this Chapter for Members on a Non-Grandfathered plan) or for cause, as described in this Chapter of the EOC.

A Member's membership may also be terminated if Health Plan stops offering this plan or 2) all Kaiser Permanente non-group plans in Hawaii. (We may terminate membership upon 90 calendar days prior written notice to the Subscriber for the former and 180 calendar days prior written notice for the latter.)

Termination for Cause

- **Fraud, or Furnishing Incorrect or Incomplete Information.** We rely upon the information contained in all documents submitted by you, and such information must be true and complete. If you (or anyone acting on your behalf) knowingly furnish incorrect or incomplete material information, or have committed fraud in connection with your membership, we may retain your membership card and terminate your membership and the membership of all the other Members in your Family Unit upon 30 calendar days written notice to the Subscriber.
- **Change that affects eligibility or benefits.** You (or anyone acting on your behalf) must advise us of any change that affects eligibility or benefits (such as a change in family status, existence of other coverage, or change in Medicare coverage status). You (or anyone acting on your behalf) must notify us in writing within 15 calendar days of such changes, otherwise we may retain your membership card and terminate your membership and the membership of all the other Members in your Family Unit upon 30 calendar days written notice to the Subscriber.
- **Misrepresentation or Misuse of Identification Card.** If you (i) knowingly misrepresents your membership status or coverage, or (ii) knowingly present an invalid prescription or physician order, or (iii) commit any type of fraud in conjunction with your membership, or (iv) knowingly misuse or permit the misuse of a Health Plan identification card, we may (i) retain the identification card, (ii) report any Member fraud to the authorities for prosecution (and pursue appropriate civil remedies) and (iii) terminate your membership and the membership of all of the other Members in your Family Unit upon 30 calendar days written notice to the Subscriber.
- **Other Rights.** In lieu of or in addition to termination rights described above, we may pursue legal claims for injunctive and/or monetary relief against you and take any other appropriate action to protect the safety of persons and property so threatened, and to recover unpaid debts or damages caused by your violation of the terms of this EOC. We may also report any Member fraud to government authorities for prosecution and pursue appropriate civil remedies.

Termination for Nonpayment

If you fail to timely pay any Monthly Premiums you owe us, Hospitals or Medical Group, we may terminate your membership and the membership of all other Members in your Family Unit upon 15 calendar days written notice to the Subscriber. Services received after the effective date of termination will be charged at full charges. After termination of your enrollment for non-payment of Monthly Premiums, we may require payment of any outstanding Monthly Premiums for prior coverage, if permitted by applicable law.

For Members on a Non-Grandfathered plan, if we terminate your membership for nonpayment of Monthly Premiums, you may not enroll in any Kaiser Permanente plan until the next annual open enrollment period or unless you experience a qualifying life event (such as marriage or divorce, birth of a child, or the loss of certain other coverage) for a special enrollment period.

Other Reasons for Termination

To the extent consistent with applicable law, Members may be terminated for any of the following reasons and subject to the notice periods provided below.

- A Member (except for Family Dependents under age 26) no longer resides in the Service Area, termination is effective upon 30 calendar days written notice.
- A Member loses eligibility, such as by divorce from a Subscriber or a child who turns 26, termination is effective as of the end of the month in which the disqualifying event occurs.
- A Member is newly eligible for Medicaid, CHIP or another health plan and enrolls in such program, termination is effective the day before such new coverage begins.
- A Member changes to another qualified health plan during an annual open enrollment period or a special enrollment period, termination is effective on the day before the effective date of the new qualified health plan.
- For Members on a Non-Grandfathered plan, Member loses eligibility for any qualified health plan, termination is effective on the last day of the month following notice from the Exchange or Health Plan, unless Member requests an earlier date.
- For Members on a Non-Grandfathered plan, Member for whom we receive payment of advance premium tax credit fails to make timely payments of Monthly Premiums or Cost Shares, termination is effective as described in the *Termination for Non-Payment* section of this Chapter.

Rescission of Membership

We may rescind your membership and the membership of all the other Members in your Family Unit after coverage becomes effective (i.e. completely cancel the membership so that no coverage ever existed), upon 30 calendar days written notice to the Subscriber, if you or any other Member in your Family Unit did any of the following:

- Performed an act, practice, or omission that constitutes fraud in connection with your membership or application for membership, or
- Made an intentional misrepresentation of material fact in connection with your membership or application for membership, such as intentionally omitting a material fact on the enrollment application.

We will send written notice to the Subscriber at least 30 calendar days before we rescind your membership, but the rescission will completely cancel your membership so that no coverage ever existed. A Member will be required to pay as a non-Member (full charges) for any services we covered. We will refund all applicable Monthly Premiums except that we may subtract any amounts owed to us. This person will not be allowed to enroll in a Kaiser Permanente health plan in the future.

Notice, Refunds, and Payments

Notice and termination if you do receive advance payment of the premium tax credit ("APTC") on your behalf

If you receive a federal premium subsidy (called an advance payment of premium tax credit or APTC), you are responsible for paying the portion of the Monthly Premiums that equals the Monthly Premiums minus the APTC that we receive on your behalf for that month. If we do not receive your portion of the Monthly Premiums on time, we will send you a notice about your failure to pay Monthly Premiums on time and your grace period (the time frame in which you must pay your overdue Monthly Premium to avoid termination) and whether coverage continues during this grace period. We will send written notice to you stating when the grace period begins due to non-payment. If we do not receive your portion of all outstanding Monthly Premiums (including any Monthly Premiums for the grace period months that are already due on the date you make your payment) by the end of the grace period, we may terminate your membership so that it ends at 11:59 pm on the last day of the first month of the grace period. You will be responsible for paying for any Services received after the termination of your coverage.

Notice and termination if you do not receive advance payment of the premium tax credits

Except where otherwise provided by the terms of this EOC and applicable law, you will receive at least 31 days prior written notice if we terminate membership for you and/or your Family Dependents for failure to pay your Monthly Premiums. The notice will state when membership will end for you and/or your Family Dependents. If you do not pay all amounts due by the end of the 31-day period, the membership for you and/or your Family Dependents will be terminated on the date in the notice provided to you.

When you may enroll after being terminated for nonpayment of Monthly Premiums

If we terminate your membership for nonpayment of Monthly Premiums, you may not enroll in any Kaiser Permanente plan until the next annual open enrollment period or unless you experience a qualifying life event (such as marriage or divorce, birth of a child, or the loss of certain other coverage) for a special enrollment period.

Refunds

If you have paid Monthly Premiums beyond the date that membership ends, you may be eligible for a refund. Any amount due to you for claims for covered medical services while you and/or your Family Dependents were Members will be paid according to your plan benefits. Any amounts you owe us will be deducted from any payment we make to you.

Survival of Certain Terms following Termination

Upon termination of this EOC or upon termination of the membership of any Member, the terms of this EOC shall survive as necessary for the limited purpose of adjudicating any claims and rights related to duties and rights arising under this EOC, including but not limited to: the *Confidentiality* section of this EOC; the duty to make payments incurred prior to termination, pursuant to the *Monthly Premium* section of this EOC; the *Continuation of Coverage*, and *Change of Residence* sections of this EOC, the *Arbitration* sections of this EOC, and this *Member Termination Provisions* section of this EOC.

Chapter 7: Filing Claims for Payment

- Claims for Payment or Reimbursement (Services from Non-Kaiser Permanente providers)
- How to File Claims

Claims for Payment or Reimbursement (Services from Non-Kaiser Permanente providers)

You must receive all your care from Kaiser Permanente providers and within Kaiser Permanente facilities with the exception of a few circumstances listed below.

- Written and authorized referral (by a Kaiser Permanente provider and/or our Authorization and Referrals department)
- Emergency Services, or out-of-state urgent care when traveling
- Certain Post-Stabilization Care Services that qualify as Emergency Services (under federal law)
- Ancillary Services at a Kaiser Permanente facility (and the Services at the facility are prior authorized)
- Dependent child benefits (as described in this Guide) while out-of-state

In most cases, the Non-Kaiser Permanente provider will submit a claim form and itemized statement describing the services received on your behalf. The Non-Kaiser Permanente provider's statement needs to include itemized statements describing services received. If you, your family members, or providers call us to inform us of your receipt of Emergency Services (including Post-Stabilization Services) or Urgent Care, we'll confirm your membership status. We review claim(s) after the Services have been provided.

If Health Plan fails to meet your expectations in the quality of care or medical service provided, you may file a grievance. If you are dissatisfied with Health Plan's denial of a medical service/item request, you have a right to appeal that denial. For a full description of procedures regarding claims, grievances or appeals, please refer to your Member Handbook or call Member Services at the phone number listed in the back of this Guide.

How to File Claims

When you receive Urgent Care outside the Service Area or when your Child Dependent obtains Services while out-of-state, you may need to pay for services up front. In this case, you may file a claim for reimbursement by sending your name (patient's name) and medical record number, paid receipt(s), medical documentation, and a written statement describing the sequence of events to the Kaiser Permanente Claims address **within 90 days** (or as soon reasonably possible) after services were received.

Kaiser Permanente Claims Address:

Kaiser Foundation Health Plan, Inc.
Attn: Claims Administration
P.O. Box 378021
Denver, CO 80237

File a separate claim for each covered family member and each provider. You should follow the same procedure for filing a claim for services received in or out-of-state or out-of-country. When we receive the claim(s) and medical information, we'll determine whether the services are covered by your Kaiser Permanente Plan. Filing a claim does not guarantee payment of that claim. If approved, reimbursement is made to providers, less your Cost Shares, according to your health plan benefits.

You may appoint someone to file the claim on your behalf. If you choose to appoint a representative, you must name this person in writing and state that they may file the claim on your behalf. Both you and your representative must sign this statement, unless the person is your attorney. When necessary, your representative will have access to medical information about you that relates to the request. If you prefer, you may call Member Services listed in the back of this guide to request an *Appointment of Representative* form.

If you have questions relating to filing a claim, please contact Member Services listed in the back of this guide. If you have questions specific to a claim already submitted, including the status of your claim, the amount paid, information relating to your cost, or the date the claim was paid, if applicable, please call Claims Administration at **1-877-875-3805**.

When a health plan like Kaiser Permanente issues an adverse benefit determination, the federal Affordable Care Act requires the health plan to notify recipients of their right to request language assistance to understand the denial notice and their appeal rights. The law also requires health plans to notify recipients of the right to request translation of the denial notice.

Language assistance is available in languages mandated by the federal Affordable Care Act:
Para obtener asistencia en Español, llame al 808-432-5955 ó 1-800-966-5955.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 808-432-5955 o di kaya'y 1-800-966-5955.

如果需要中文的帮助，?拨打?个号码 808-432-5955 或者1-800-966-5955。
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 808-432-5955 doodaii 1-800-966-5955.

Chapter 8: Dispute Resolution

- How to File an Appeal
- Binding Arbitration
- Initiating Arbitration
- Arbitration Proceedings
- General Provisions
- Arbitration Confidentiality
- Special Claims

How to File an Appeal

Standard Appeal

If we deny your request for coverage as a result of our UM review or payment of a benefit claim, you have the right to file an appeal to ask that we reconsider our decision. Generally, we'll issue a written notice that tells you the specific reasons why we denied coverage or payment for the item or service. The notice will describe your appeal rights and how to file an appeal. You must submit your appeal within 180 days of the date of our denial notice.

You may appoint someone to file the appeal on your behalf. If you choose to appoint a representative, you must name this person in writing and state that they may file the appeal on your behalf. Both you and your representative must sign this statement, unless the person is your attorney. When necessary, your representative will have access to medical information about you that relates to the request. If you prefer, you may call Member Services at 1-800-966-5955 to request an *Appointment of Representative* form.

You may file your appeal by mailing or delivering your request to:

Kaiser Foundation Health Plan, Inc.
Attn: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813

Include in your appeal your name, the patient's name and Kaiser Permanente medical record number, the date, the nature of our decision that you're appealing, and all comments, documents, and other information you want us to consider regarding your appeal. Fax your appeal to **808-432-5260** or file it by electronic mail at **KPHawaii.Appeals@kp.org**. If you have questions about the appeals process, you may call Member Services. Our phone numbers are listed at the back of this guide.

Standard appeals must be filed on weekdays during office hours, from 7 a.m. to 7 p.m. The receipt date for appeals filed after office hours or on weekends will be the next business day.

When received, your appeal will be prepared for an internal review. Appeal reviews will consider all information you submit (whether or not that information was submitted with your initial request for payment or coverage), will be decided by a different reviewer than the person who denied your initial request, and will not give deference to the initial decision you're appealing. When you appeal, you may give testimony in writing or by telephone. Please call Member Services to get information about giving testimony by phone. If we consider, rely upon or generate any new or additional evidence in our appeal review, or if our appeal decision is based on a new or additional coverage rationale, we will provide you, free of charge, such evidence or coverage rationale as soon as possible and give you a reasonable opportunity to respond before our decision is due. If you do not respond before we must make our decision, our decision will be based on the information that we have on hand. If we continue to deny your request after our appeal is completed, our written notice to you will include the specific reasons for the decision and refer to the specific plan provisions on which our decision was made. If you are not satisfied with our decision, you may request external review as noted in this guide.

Appeals related to claims for payment (post-service requests) filed by members on employer group plans will be processed through two internal levels of review. When received, your post-service appeal will be prepared for a first-level review. Generally, we will provide you with our written decision within 30 calendar days. If you are not satisfied with the first-level decision, you may request a second-level review by our Regional Appeals Committee within 60 days of the date of the first-level decision letter. We'll acknowledge receipt of your second-level appeal and provide you with our written decision within 30 calendar days of our receipt of the request. Appeals filed by members on non-group or individual plans (Obtained ON or OFF the Marketplace) will be completed through a single level review and decisions communicated in writing within 60 calendar days of receipt of the appeal.

You may request a free copy of all documents and information relevant to your initial claim and appeal; any rule, guideline, or protocol we relied upon in denying the service or supply you requested; and the identity of any experts whose advice was obtained by us in connection with our denial of your request. You can request the information by calling Member Services. Our phone numbers are listed in the back of this guide.

You also have the right to request the diagnosis and treatment codes and their meanings that are the subject of your claim. You can request this information by calling Claims Administration Member Services at **1-877-875-3805**.

When a health plan like Kaiser Permanente issues an adverse benefit determination, the federal Affordable Care Act requires the health plan to notify recipients of their right to request language assistance to understand the denial notice and their appeal rights. The law also requires health plans to notify recipients of the right to request translation of the denial notice. Language assistance is available in languages mandated by the federal Affordable Care Act:

Para obtener asistencia en Español, llame al 808-432-5955 ó 1-800-966-5955.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 808-432-5955 o di kaya'y 1-800-966-5955.
如果需要中文的帮助，?拨打?个号码 808-432-5955 或者1-800-966-5955。
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 808-432-5955 doodaii 1-800-966-5955.

Expedited Appeal

You may ask that we make an expedited decision on your appeal. The expedited procedure applies to denied requests for services or supplies that you have not yet received, or are currently receiving that are being reduced or terminated. It does not apply to denied requests for payment for services or supplies that you have already received. We'll make an expedited decision in less than 72 hours if we find, or if your Physician states, that reviewing your appeal under the 30-day process would seriously jeopardize your life or health, seriously affect your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting. Our decision may take longer if we have to wait for information from you or medical records about your case, but we must make a decision within 72 hours of our receipt of such additional information.

You or your Physician may request an expedited appeal anytime by calling toll free **1-866-233-2851**, or by faxing, writing, or delivering your request to the same address and phone numbers listed for standard appeals. If we determine that your request does not meet the criteria for an expedited appeal, we'll automatically review your written appeal under the 30-day process.

Different procedures apply to the following plans: Kaiser Permanente Senior Advantage and Kaiser Permanente QUEST Integration. Members on these plans should consult their respective Evidence of Coverage, or brochure for a description of the claims and appeals procedures that apply to them.

External Appeal with an Independent Review Organization

Once you've exhausted your internal appeal rights and we've continued to deny coverage or payment as stated in any final adverse benefit determination (ABD) notice that you receive from us, you can request an external appeal with an independent review organization (IRO) for our final adverse benefit determination that

- relies on medical judgment (including but not limited to medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered service),
- concludes that the requested care or service is experimental or investigational,
- concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or substance abuse) benefits,
- involves consideration of whether We are complying with federal law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130), or
- involves a decision related to rescission of your coverage.

If our appeal decision to deny your request for coverage or payment does not involve medical judgment or medical information, then your request is not eligible for external review.

An IRO is independent from Kaiser Permanente and has the authority to overturn our denial of coverage or payment. The IRO that is responsible for conducting your external appeal is based on your KP plan.

Our appeal notice will contain information about the IRO that applies to you and instructions on filing an external appeal with the IRO. You may also be able to simultaneously request external review as permitted under federal law in connection with an expedited internal appeal.

You, your appointed representative, or treating provider (in the case of an expedited review) may file the request for external review by the Hawaii Insurance Commissioner. Requests for external review must be submitted to the commissioner within 130 days of receipt of Kaiser Permanente's final adverse decision. Requests for external review may be filed at the address below or by facsimile to **808-587-5379**. You can reach the Health Insurance Branch of the Hawaii Insurance Division by calling **808-586-2804**.

State of Hawaii DCCA
Insurance Division - External Appeals
335 Merchant St., 2nd Fl.
Honolulu, HI 96813

If the request is determined eligible for external review, the commissioner will assign the case to an IRO approved by the Insurance Division within three business days. Once assigned, the IRO will notify you and Kaiser Permanente within five business days that the external appeal has been opened for review. We must submit to the IRO within five business days of our receipt of the notice from the IRO all the documents and information that we considered during our internal review of your request. You or your authorized representative may submit additional written information to the IRO within five business days of your receipt of the notice from the IRO.

The IRO will perform the external review by considering the information noted above and the terms of your Kaiser Permanente plan as well as your medical records, any recommendations from your attending health care professional, additional consulting reports from appropriate health care professionals, the medical necessity statute defined under Hawaii law (Hawaii Revised Statutes Chapter 432E-1), the most appropriate practice guidelines, any applicable clinical review criteria developed and used by Kaiser Permanente, and the opinion of the IRO's clinical reviewer. The IRO will not be bound by our initial and appeal adverse decisions in deciding your external appeal. The IRO will send you its decision in writing within 45 days of receiving your external review request. In the event the IRO reverses our adverse decision, we must immediately cover or pay for the service or item that you are requesting.

Expedited External Appeal

Expedited review may be requested from the commissioner by you, your authorized representative, or health care provider if processing under the standard timeframe would result in serious jeopardy to your life or health, seriously affect your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting. Expedited review may also be requested from the commissioner if your appeal involves admission to a facility for health care services, the availability of care or a continued stay at a facility for health care services, or a health care service that you are receiving during an Emergency visit before you are discharged from the

facility where the Emergency services are being obtained. If your request qualifies for expedited processing at the time you receive our initial ABD or file your internal appeal, you have the right to simultaneously request expedited review with the commissioner. The expedited process does not apply to services or items that you have already received.

If the request is determined eligible for expedited external review, the commissioner will immediately assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must transmit to the IRO in an expeditious manner all the documents and information that we considered during our internal review of your request.

The IRO will perform the external review by considering the same types of information as noted earlier under the standard process. The IRO will not be bound by our initial and appeal adverse decisions in deciding your external expedited appeal. The IRO will notify you of its decision as expeditiously as your medical condition or the circumstances require, but in no event more than 72 hours of its receipt of your eligible expedited request. If its decision was provided verbally at first, then the IRO must send written confirmation within 48 hours of its verbal notice. In the event the IRO reverses our adverse decision, we must immediately cover or pay for the service or item that you are requesting.

External Review Requests for Experimental or Investigational Services or Treatments

Additional procedures apply to a request involving an experimental or investigational service or treatment. You or your authorized representative may make an oral request for expedited review if your treating physician certifies in writing that the service or treatment you are requesting would be significantly less effective if it was not initiated promptly. This certification must be filed promptly with the commissioner following your oral request for review. If you or your authorized representative request expedited review in writing rather than orally, you must include your treating Physician's written certification with the written request. If your request is determined eligible for expedited review, the commissioner must immediately assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must transmit to the IRO in an expeditious manner all the documents and information that we considered during our internal review of your request.

Within three business days after being assigned to perform the external review, the IRO will select one or more clinical reviewers who are experts in the treatment of the condition and knowledgeable about the service or treatment that is the subject of the request. Each clinical reviewer must provide an opinion regarding whether the service or treatment should be covered. This opinion must be provided to the IRO orally or in writing as expeditiously as your condition requires but in no event more than five calendar days after the reviewer was selected. If the opinion was provided orally, then the reviewer must provide a written report to the IRO within 48 hours following the date the oral opinion was provided. The IRO must provide you, your authorized representative, and Kaiser Permanente with its decision either orally or in writing within 48 hours after it receives the opinion. If its decision was provided orally, then the IRO must send its decision in writing within 48 hours of the oral notice. If a majority of the clinical reviewers recommend that the service or treatment should be covered, then the IRO must reverse Kaiser Permanente's adverse decision. If a majority of the reviewers recommend that

the service or treatment should not be covered, then the IRO will make a decision to uphold Kaiser Permanente's adverse decision. If the reviewers are evenly split as to whether the service or treatment should be covered, then the IRO must obtain the opinion of another clinical reviewer. The processing timeframes are not extended if the IRO needs to obtain the opinion of an additional reviewer.

For non-expedited requests involving an experimental or investigational service or treatment that are determined eligible for external review, the commissioner has three business days after the eligibility decision was made to assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must submit to the IRO within five business days of our receipt of the name of the IRO all the documents and information that we considered during our internal review of your request. You or your authorized representative may submit additional written information to the IRO within five business days of your receipt of the Insurance Division's notice that your case was assigned to an IRO. The IRO must select one or more clinical reviewers within three business days after it was assigned to perform the external review. Each reviewer must provide its opinion to the IRO in writing within 20 days of the date the IRO was assigned to perform the review. The IRO must then provide its written decision to you, your authorized representative, and Kaiser Permanente within 20 days after the opinions were received. The IRO must decide to reverse or uphold Kaiser Permanente's adverse decision in the same manner discussed earlier based on a majority of the clinical reviewers' recommendations.

Procedures Applicable to All Requests for External Review

The IRO's decision is binding on you and Kaiser Permanente except for any additional remedies that may be available to you or Kaiser Permanente under applicable federal or state law. You or your authorized representative may not file a subsequent request for external review involving the same adverse decision for which you already received an external decision.

When filing any request for external review, you must include a copy of Kaiser Permanente's final ABD with your request, unless you are seeking simultaneous expedited external review, or we have substantially failed to comply with our internal appeals procedures. You or your authorized representative will also be required to authorize the release of your medical records that need to be reviewed for the external appeal, as well as provide written disclosure that permits the commissioner to perform a conflict of interest evaluation as part of the selection process for an appropriate IRO. You can find forms that meet each requirement on our website at **kp.org** or by calling Member Services at the phone number listed in the back of this guide. Lastly, a $15 filing fee must be included with the external appeal request. The filing fee will be refunded if Kaiser Permanente's adverse determination is reversed through the external review, or the commissioner waives the fee because it poses an undue hardship on you. Your request will be considered incomplete, and the external review delayed if you do not submit all the required information with the request.

When you submit a request for external review, the commissioner will inform Kaiser Permanente about your request. We will be responsible for notifying the commissioner and you or your authorized representative in writing whether the request is complete and eligible for external review. If we believe

your request is not eligible for external review, you may file an appeal with the commissioner. Our notice of ineligibility will include information on requesting this appeal.

You must exhaust Kaiser Permanente's internal claims and appeals process before you may request external review, except when external review is permitted to occur simultaneously for requests that qualify for expedited review, or we have failed to comply with applicable claims and appeals requirements under federal or state law. You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures and external review. If you are enrolled through a plan that is subject to ERISA, you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-3272**. Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

Different procedures apply to the following plans: Kaiser Permanente Senior Advantage, Kaiser Permanente QUEST Integration, and the Federal Employees Health Benefits Program. Members on these plans should consult their respective Evidence of Coverage, or brochure for a description of the independent external review procedures that apply to them.

Binding Arbitration

Except as provided in this chapter or by applicable law, any and all claims, disputes, or causes of action arising out of or related to this EOC, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

This includes but is not limited to any claim asserted:

By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this EOC, all family members of the member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;

On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this EOC, except when binding arbitration is explicitly not permitted by applicable law, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and

By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):

- Kaiser Foundation Health Plan, Inc.,
- Kaiser Foundation Hospitals,
- Hawaii Permanente Medical Group, Inc.,
- The Permanente Federation, LLC,
- Any individual or organization that contracts with an organization named above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

Notwithstanding any provisions to the contrary in this EOC, the following claims shall not be subject to mandatory arbitration:

- claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- actions for appointment of a legal guardian of a person or property subject to probate laws;
- purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services (such as temporary restraining orders, and emergency court orders).

Initiating Arbitration

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at Kaiser Foundation Health Plan, Inc., Member Services, 711 Kapiolani Boulevard, Honolulu, HI 96816. The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration Proceedings

Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery of less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for:

- production of documents that are relevant and material,
- taking of brief depositions of treating Physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and
- independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties.

Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this EOC or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review.

The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial.

With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, *9 U.S.C. Chapter 1.*

General Provisions

All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this EOC in any particular case, then such term(s) shall be severable in that case and the remainder of this EOC shall not be affected thereby. Class actions and consolidation of

parties asserting claims regarding multiple members or patients are prohibited. The arbitration provisions in this EOC shall supersede those in any prior EOC.

Arbitration confidentiality

Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

Special Claims

Medical Malpractice Claims

Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. Following the rendering of an advisory decision by the Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in in the "Initiating arbitration" section.

External Appeal of Internal Review Decisions

If you disagree with Kaiser Permanente's final internal benefit determination, you may request voluntary binding arbitration pursuant to the procedures in this EOC.

In addition to the arbitration procedures set forth in this EOC, which may be elected by the Member (but are not mandatory) Hawaii Revised Statutes Chapter 432E also creates certain external review rights for Members to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final internal determination. These rights are subject to the limitations noted in the next paragraph, and are subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals procedures is described in the "Appeals" section of this EOC.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. Health Plan may object to external reviews under Chapter 432E which do not meet the standards for external review under applicable federal and state law, and Health Plan reserves its full rights and remedies in this regard. The recitation of State law provisions shall not be deemed to constitute any waiver of such objections.

Chapter 9: Coordination of Benefits

- Coordination of Benefits
- If You are Hospitalized When Coverage Begins
- Medicare
- Workers' Compensation or Employer's Liability
- Special provisions for Members Entitled to Medicare Benefits
- U.S. Department of Veterans Affairs

Coordination of Benefits

You may have other insurance coverage that provides benefits that are the same or similar to this plan. The Services covered in this EOC are subject to coordination of benefits (COB) rules. If you have dental or medical coverage with another health plan or insurance company, we will coordinate benefits with the other coverage in accordance with the current National Association of Insurance commissioners (NAIC) Model Regulation Rules for Coordination of Benefits. Those rules are incorporated into this EOC.

If You Are Hospitalized When Coverage Begins

If you are hospitalized when your coverage begins, you will be covered under this EOC in accord with your hospital benefit on that same coverage effective date. See the *Effective Date of Coverage* section in *Chapter 6: Membership Information* of this Guide.

Medicare

After joining this plan, Members may become eligible for or entitled to coverage under Medicare (such as Parts A and/or B) due to age, disability or end stage renal disease. A Member who is or becomes eligible for coverage under Medicare, should promptly contact the Member Services Center at the phone number in the back of this Guide, to give us notice of such eligibility and to receive information about our Senior Advantage Plan.

Workers' Compensation or Employer's Liability

If you have or may have coverage under worker's compensation insurance for an illness or injury, please note that the medical expenses arising from injuring or illness covered under worker's compensation insurance are excluded from coverage under this EOC.

Financial responsibility for medical services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), that is provided under any workers' compensation or employer's liability law is not covered under this EOC. We will provide medical services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value (calculated at full charges) of any such medical services provided under this EOC from the following sources:

- any source providing a Financial Benefit or from whom a Financial Benefit is due
- from you, to the extent that a Financial Benefit is provided or payable

We reserve the right to bill your employer or your employers' worker's compensation carrier for medical services provided under this EOC.

If you receive payment from the proceeds of a settlement, judgment or other payment received from or on behalf of your employer or employer's worker's compensation insurance carrier, you shall repay Health Plan first from any payments received, for the value of medical services provided calculated at full charges.

You are responsible for notifying us of any "work injury", as defined by Chapter 386, Hawaii Revised Statutes, Section 1-3. If you receive any payment under any workers' compensation or employer's liability law on account of the injury or illness, and you give us (or our nominees) back all amounts (up to the value of medical services received computed at full charges), charges for medical services provided under this EOC will be canceled to the extent they exceed the amount recovered. If there is no recovery, all charges provided under this EOC will be canceled.

Third Party Liability Injuries (including motor vehicle accidents)

If you are or may be entitled to medical benefits from third party liability injuries (including your automobile coverage, you must exhaust those benefits first, before receiving benefits from us. You are responsible and must pay us full charges for medical services and items you receive (or for which we have made payment) for injury or illness that is:

- Caused or alleged to be caused by any act or omission of another party giving rise to a legal claim again another party, insurer, or organization, or
- Incurred in a motor vehicle accident, irrespective of fault
- (both herein referred to as "Third Party Liability Injuries")

However, with regard to covered medical services received, and subject to the "General Provisions" section below,

If you make reasonable efforts to obtain payment for Third Party Liability Injuries, and

Remit to us all amounts received (up to the value of the covered medical services received computed at full charges) whether from settlement, judgment, under liability coverage, as medical payments under Hawaii Motor Vehicle Accident Reparations Act ("Hawaii Motor Vehicle Insurance Law"), under any state or federal legislations of similar purpose or import, or any other source, and regardless of whether or not you have been fully compensated or made whole. Then charges for covered medical services are satisfied to the extent they exceed the amount recovered by you (or your estate, parent or legal guardian) from or on behalf of the other party. In addition, the amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum.

These provisions do not affect your obligations to pay your applicable Cost Shares.

You must immediately make payment to us from the proceeds of any settlement, judgment or other payment received from or on behalf of any other party, insurance company or organization for Third Party Liability Injuries, and we (or our designee) shall have a first priority lien on the settlement, judgment or other payment for that purpose.

Your duty of repayment applies to any such settlement, judgment or other payment proceeds obtained, even if such proceeds do not specifically include medical expenses, or are stated to be for general damages only, or are obtained on your behalf by a parent, estate, or legal representative, or are distributed to other persons, or are obtained without any admission of liability or causation by the third-party payor. No reductions for attorneys' fees, costs or other expenses may be made from the amounts owing us for Third Party Liability Injuries.

At our (or our designee's) request, you (or your estate, parent or legal guardian) shall execute a lien form directing your attorney or the third party to make payments due hereunder directly to us (or our designee). Our rights under this section will be enforceable regardless if you execute the lien form.

Our right to reimbursement shall include, but is not limited to, any recovery you receive from uninsured motorist coverage, underinsured motorist coverage, workers compensation coverage, no-fault, or any other liability coverage.

General Provisions

The benefits provided under this section (including cancellation of charges) are not available to the extent of all medical-rehabilitative benefits to which you were entitled under your auto insurance policy or the Hawaii Motor Vehicle Insurance Law, prior to any use, transfer or exhaustion of said benefit by you, which you do not use to pay for medical services or items under this section.

You must do all of the following:

- Cooperate in protecting our interests under these sections,
- Execute and deliver to us (or our designee) all liens, assignments, consents, releases, authorizations, or other documents which we determine are necessary and proper to determine the applicability of and enforce our rights under this section,
- Authorize and direct any person (including your attorney) making any payment on account of any such injury or illness to pay us (or our designee) in order to discharge your obligations under this EOC,
- Not take any actions prejudicial to our rights/interests, and
- Within 30 calendar days after submitting or filing a claim or legal action against a third party arising from alleged acts or omissions (or anticipation of such), you must send written notice of the claim or legal action to:

Equian
Kaiser Permanente - Hawaii Region

Subrogation Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: 1-502-214-1137

We have the option of becoming subrogated to all claims and causes of action that you may have against another party, insurer, or organization for damages on account of Third Party Liability Injuries.

We shall have a first priority lien on the proceeds of any settlement or judgment for Third Party Liability Injuries. The provisions of this section apply even if the total amount of the recovery on account of the injury or illness is less than your actual loss and regardless of how the proceeds are characterized or itemized.

To be eligible for partial or complete cancellation of charges, or to have payments made under the "Emergency Services" section, you must comply with the provisions of this "Third party liability injuries (including motor vehicle accidents)" section.

Special Provisions for Members Entitled to Medicare Benefits

When Hospitals have provided Services to a Medicare Member for Third Party Liability Injuries, Hospitals will, in compliance with federal law, seek reimbursement under the medical expense payment provisions of any motor vehicle insurance policy covering the Member. Each such Member must furnish information about the existence and terms of any such policy, and complete and submit all claims, releases and other documents necessary for Hospitals to comply with federal law.

U.S. Department of Veterans Affairs

You are not covered for Services for any military service-connected illness, injury or condition when the law requires such Services to be provided only by or received only from a government agency. However, we may cover such Services if we are able to recover the value of the Services from the Department of Veterans Affairs. For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs.

Chapter 10: Additional Plan Provisions

- Confidentiality
- Privacy information
- Relation Among Parties Affected by this EOC
- Miscellaneous Provisions

Confidentiality

Your Medical Records and Confidentiality

Patient-identifying information from your medical records and patient-identifying information received by us incident to the Physician-patient or hospital-patient relationship is kept confidential and is not disclosed without your prior consent, except as authorized by state or federal law.

By enrolling in our plan with us, you authorize us to obtain and use information from your medical records and billing records (including providing this information to agents and employees of us) for purposes of Health Plan operations, medical treatment, claims processing, quality assurance, provider peer review, research, education, and compliance with government regulations and accreditation requirements. You must sign and submit to us all consents, releases, and other documents reasonably necessary for us to obtain access to your medical records and billing records not held by us, to the extent reasonably necessary for the above stated purposes.

Privacy Information

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

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

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes such as quality assessment and improvement, customer service, and compliance programs. Sometimes, we contract with others (business associates) to perform services for us and in those cases, our business associates must agree to safeguard any PHI they receive.

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

For a more complete explanation of our privacy policies, please request a copy of our Notice of Privacy Practices, which is available on our website www.kp.org/privacy, in our medical offices, or by calling Member Services. If you have questions or concerns about our privacy practices, please contact Member Services listed on the back cover of this EOC.

Relation Among Parties Affected by this EOC

Independent Contractors

You are not the agent or representative of Health Plan. Health Plan is not a representative nor an agent of you. You are not liable for any act or omission of: Health Plan, its agents or employees; Medical Group; any Physician; Hospitals; or any other person or organization with which Health Plan has made or hereafter makes arrangements for performance of services under this EOC. Health Plan is not liable for any act or omission of you or your agents.

Physicians maintain the Physician-patient relationship with you, and are solely responsible for all medical services to you. Hospitals maintain the hospital patient relationship with you and are solely responsible for all Hospital Services to you.

Relations in the Event of Termination

If the contracts between Health Plan and Medical Group, or between Health Plan and Hospitals, or between Health Plan and any other contracting provider, are terminated while this EOC is in effect and while you are under the care of such provider, Health Plan will retain financial responsibility for care by that provider which is covered under this EOC, in excess of any applicable Deductible or Cost Shares, until Health Plan makes arrangements for such medical services to be provided by another contracting provider.

The contracts between Health Plan and Medical Group and between Health Plan and Hospitals provide that you are not liable for any amounts owed Medical Group or Hospitals by Health Plan. However, a Member may be liable for the cost of any services obtained from a non-contracting provider.

Miscellaneous Provisions

Applications, Statements, and Questionnaires

Members or applicants for membership shall complete and submit to us such applications, medical review questionnaires, medical records release authorizations, or other forms or statements as we may reasonably request.

Assignment

Neither this EOC nor any of the rights, interest, claims for money due, benefits or obligations hereunder shall be assigned by you to another party, including any contracted and non-contracted health care providers, without our prior written consent, and any attempt to do so without our prior written consent shall be void.

Direct submission of a claim by any provider on behalf of you, direct reimbursement to any provider, or the appointment by you of an authorized representative, or any other action permitted by the EOC, or other documents relating to administration of benefits do not imply consent to an assignment or alter this prohibition on assignments.

Attorney Fees and Costs

Unless stated otherwise in this EOC, each party shall pay for their own costs, attorney fees, and attorney expenses incurred as a result of any claim or dispute arising out of an alleged violation of a legal duty incident to this EOC.

Charge for Insufficient Funds

You may be assessed a charge for any payment to us that is returned due to insufficient funds in your bank account.

Compliance with Laws

Subscriber, Subscriber's Family Dependents and Health Plan shall comply with all applicable federal and state laws (such as Hawaii's autism law, Hawaii's child health supervision services law, and the Hawaii Our Care Our Choice Act), rules and regulations when performing duties or exercising rights related to this EOC. This includes Subscriber and Health Plan satisfying all applicable requirements under the Patient Protection and Affordable Care Act (PPACA) and related federal health care reform laws and regulations. To the extent required by PPACA, Health Plan will provide electronic or paper summaries of benefits and coverage (SBCs) to Subscribers.

For Members on Non-Grandfathered plan, Health Plan shall also comply with all health care related requirements set forth by the PPACA regarding Essential Health Benefits (EHB) and benchmark plan benefits, to the extent required by law to be provided by Health Plan.

EOC Binding on Members

By electing coverage pursuant to this EOC, paying Monthly Premiums, or receiving medical services, you accept and agree to all terms, conditions and provisions of this EOC for yourself and your Family Dependents. To be eligible for coverage, Members and applicants for membership must complete any applications, forms or statements that we reasonably request.

EOC Implementation

We may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient implementation of this EOC.

EOC Modification

We may modify this EOC with respect to any matter, effective as of the anniversary date of this EOC. If we do, we will notify you in writing of material benefit changes at least 30 calendar days before the changes are effective. Health Plan may also amend this EOC at any time with respect to any matter (including rates) as it relates to changes required by state or federal law, or state or federal regulators. If you continue to pay the

Monthly Premiums or receive medical services provided or arranged by us after the change has gone into effect, you thereby agree to the changes. Your consent also covers your enrolled Family Dependents.

EOC Term

This EOC continues in effect from January 1st of each year (or such later date on which Subscriber first enrolls) through December 31st of that same year unless it is terminated earlier. This EOC does not automatically renew. We will offer you a new EOC to become effective immediately after termination of this EOC. If this EOC terminates pursuant to the *Member Termination Provisions* section of this Guide, or is non-renewed in accordance with applicable law (including for cause or non-payment as described in the *Member Termination Provisions* section of this Guide), we reserve the right to not offer you a new EOC, in accordance with applicable law.

Essential Health Benefits (for Members on a Non-Grandfathered ACA plan)

Essential Health Benefits (EHBs) are benefits that the U.S. Department of Health and Human Services (HHS) Secretary defines as essential health benefits. Essential Health Benefits 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. These Essential Health Benefits are subject to change at any time to conform to applicable laws and regulations. This list is available through Member Services.

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.

Essential Health Benefits are provided upon payment of the Cost Shares listed in the Benefit Summary in in the front of this Guide.

Payments toward Essential Health Benefits count toward the Member's Annual Copayment Maximum, as described in the Benefit Summary in the front of this Guide and Chapter 2: Payment Definitions and Information.

Governing Law

Except as preempted by federal law or expressly specified otherwise in this EOC, this EOC will be governed in accord with Hawaii law.

Identification Cards

Cards issued by us to you pursuant to this EOC are for identification only. Possession of a Health Plan identification card confers no rights to medical services or other benefits under this EOC. To be entitled to such medical services or benefits the holder of the card must, in fact, be a Member on whose behalf all charges under this EOC have been paid. Any person receiving medical services or other benefits to which they are not then entitled pursuant to the provisions of this EOC is responsible for the cost of those medical services at full charges.

Notices

Any notice under this EOC may be given by United States Mail, postage prepaid, addressed as follows:

If to Health Plan:

KAISER FOUNDATION HEALTH PLAN, INC.
Member Services Department
711 Kapiolani Boulevard
Honolulu, Hawaii 96813

If to a Member:

To the latest address provided for the Member on enrollment or change of address forms actually delivered to Health Plan.

No Waiver

Failure by us to enforce any term or condition of this EOC will not be considered a waiver or an impairment of our right thereafter to require strict performance of any term or condition by Member. Without waiver of these terms, we reserve the right to establish criteria for alternative treatment plans for certain medical conditions that require costly, long-term, or extensive care, and alternative payment plans for extenuating circumstances where you are unable to pay any applicable Deductible or Cost Share on a timely basis under this EOC; provided that we and you must mutually agree in writing to the terms of such alternative plans.

Oral Statements

No oral statement of any person shall modify or otherwise affect the benefits, limitations, and exclusions of this EOC, convey or void any coverage or increase or reduce any benefits under this EOC.

Overpayment

We may recover any overpayment it makes for services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the services.

Refusal to accept treatment

Certain Members may, for personal reasons, refuse to accept procedures or treatment recommended by Physicians. Physicians may regard such refusal as incompatible with the continuance of a satisfactory physician-patient relationship and as obstructing the provision of proper medical care. Physicians use their best efforts to render all necessary and appropriate professional services in a manner compatible with a Member's wishes, insofar as this can be done consistently with the Physician's judgment regarding proper medical practice. If a Member refuses to follow a recommended treatment or procedure for a condition, and the Physician believes that no professionally acceptable alternative exists, the Member will be so advised. If the Member still refuses to follow the recommended treatment or procedure, then neither Medical Group, Hospitals, Health Plan nor any Physician has any further responsibility to provide any alternative treatment or procedure sought by Member for that condition.

Severability

If any term(s) in this EOC is found invalid under applicable law, the validity of the remaining portions of this EOC shall not be affected and the rights and duties hereunder shall be construed and enforced as if this EOC did not contain the term(s) held to be invalid.

Special Claims and Appeals Provisions for Medicare Members

Claims and appeals related to Medicare benefits for Members are governed by federal regulations which must be observed by us and Members. Explanation is given in the Member's EOC.

Chapter 11: Glossary

As used in the EOC, the terms in boldface type, when capitalized, have the meanings shown.

ACA: Refers to the Affordable Care Act, a federal health care law also known as the Patient Protection and Affordable Care Act ("PPACA").

Ancillary Service: Services that are:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner
- Items and services provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services, including radiology and laboratory services
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-Plan Provider satisfies the notice and consent requirements (to waive your rights against surprise billing/balance billing under applicable state or federal law) under federal law.

Annual Copayment Maximum: The Annual Copayment Maximum is the maximum Cost Share you pay out of your pocket in a calendar year. Once you meet the Annual Copayment Maximum you are no longer responsible for Cost Share amounts for eligible covered Services, unless otherwise noted.

Applicable Charges:

For professional services, Applicable Charges mean:

- When Medical Group or Health Plan Hospital provides medical Services to a Member, then Member Rates are used,
- When a contracted non-Medical Group practitioner or a contracted non-Health Plan facility provides medical Services to a Member, the Applicable Charge is the negotiated rate,
- When a non-contracted non-Medical Group practitioner or a non-contracted non-Health Plan facility provides medical Services other than Emergency Services (including Post Stabilization Services) or Ancillary Services to a Member, the Applicable Charge is the fee that we determine to be usual, reasonable and customary. This means a fee that:
    - does not exceed the fees accepted as payment for similar Services by other providers; and
    - is in accord with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

  For Emergency Services or Ancillary Services, the Applicable Charge shall be the amount required to be paid under applicable federal law including any amount owed pursuant to open negotiation or independent dispute resolution.

For other medical Services or items, Applicable Charges mean:

- When Kaiser Permanente provides medical Services or items to a Member, then Member Rates are used,
- When a contracted provider or facility provides medical Services or items to a Member, then Applicable Charges is the negotiated rate,
- When a non-contracted provider or facility provides medical Services or items to a Member other than Emergency Services (including Post-Stabilization Services) or Ancillary Services, the Applicable Charge is the fee that we determine to be usual, reasonable and customary. This means a fee that:
    - does not exceed the fees accepted as payment for similar Services by other providers; and
    - is in accord with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

  For Emergency Services (including Post-Stabilization Services, the Applicable Charge shall be the amount required to be paid under applicable federal law including any amount owed pursuant to open negotiation or independent dispute resolution.

CHIP: The Children's Health Insurance Program provides health insurance coverage for children that do not qualify for Medicaid, but remain in families that cannot afford to purchase health insurance.

Cost Share: A Cost Share applies to most covered Services. It is either a fixed percentage of Applicable Charges or a fixed dollar amount. In addition to Cost Share, please refer to Annual Deductible if your plan has a Deductible.

Covered Services: Services or supplies that meet payment criteria and are either: 1. Listed in this Guide in *Chapter 3: Benefit Description* or 2. Not listed in this guide in *Chapter 4: Services Not Covered.*

Deductible: The Annual Deductible is the amount you must pay for certain covered medical Services in a calendar year before Kaiser Permanente will cover those Services. Once you meet the Annual Deductible, you are no longer responsible for deductible amounts for the remainder of the calendar year, and you pay the Cost Share for the covered Services. Each member Annual Deductible counts toward the family unit Annual Deductible amount.

Dependent Child: The dependent (biological, step, or adopted) child of the Subscriber or the Subscriber's Spouse as described in *Chapter 6: Membership Information* of this Guide.

Emergency, or Emergency Medical Condition: a medical condition including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious risk to the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child)
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Evidence of Coverage (EOC): This Kaiser Permanente Hawaii Guide to your Health Plan (Guide), Riders, application/enrollment form, and amendments.

Family Dependent: Any person (i) who meets all applicable eligibility requirements in *Chapter 6: Membership Information* of this EOC; (ii) who is enrolled hereunder; and (iii) for whom the prepayment required in *Chapter 2: Payment Definitions and Information* of this EOC and has been received by us.

Family Unit: A Subscriber and all of his or her Family Dependents on the same plan with the same benefits.

Foster child: An individual who is placed with you by and authorized placement agency or by judgement, decree, or other court order.

Grandfathered Plan: A health insurance policy purchased on or before March 23, 2010, which has not made changes outlined in the Affordable Care Act that would cause the plan to lose Grandfathered status. These plans are exempt from some of the rights and protections provided under the Affordable Care Act.

Guide: The document called the "Kaiser Permanente Hawaii's Guide to Your Health Plan."

Health Plan: Kaiser Foundation Health Plan, Inc., Hawaii Region, a California nonprofit corporation.

Health Plan Region: Each of the specific geographic areas where Kaiser Foundation Health Plan, Inc., or a related organization conducts a direct service health care program.

Hospital: Any hospital in the Service Area to which you are admitted to receive Hospital Services pursuant to arrangements made by a Physician. A current list of Hospitals may be obtained from the Member Services.

Hospital Services: Except as expressly limited or excluded by this EOC, those Medically Necessary medical services for acute care registered bed patients that are (i) generally and customarily provided by acute care general hospitals in the Service Area; and (ii) performed, prescribed, or directed by the Physician, or authorized in writing by the Medical Group.

Independent Freestanding Emergency Department: A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.

Kaiser Permanente: The program composed of Kaiser Foundation Health Plan, Inc., Hawaii region, (a nonprofit corporation), Kaiser Foundation Hospitals (a nonprofit corporation), and Hawaii Permanente Medical Group (a for-profit professional corporation or partnership).

Medical Group: Hawaii Permanente Medical Group, Inc.

Medically Necessary: means Services that meet all of the following criteria:

- Recommended by the treating PCP or Kaiser Permanente licensed health care practitioner,
- Approved by the Kaiser Permanente's medical director or designee,
- For the purpose of treating a medical condition,

- The most appropriate delivery or level of Service, considering potential benefits and harms to the patient,
- Known to be effective in improving health outcomes provided that:
    - Effectiveness is determined first by scientific evidence;
    - If no scientific evidence exists, then by professional standards of care; and
    - If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
    - Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.
- And Services that are not known to be effective in improving health outcomes include, but are not limited to, Services that are experimental or investigational.

All covered Services must be Medically Necessary, prescribed, and consistent with reasonable techniques specified under this EOC with respect to the frequency, method, treatment, or licensing or certification to the extent the provider is acting within the scope of the provider's license or certification under applicable Hawaii State law.

Medical Office: Any outpatient treatment facility staffed by Medical Group. A current list of Medical Offices may be obtained from the Member Services.

Medicare: The Federal Health Insurance Program for people 65 years or older, people under age 65 with certain disabilities, and people of any age with End Stage Renal Disease (ESRD).

Member: Any Subscriber or Family Dependent.

Kaiser Permanente Senior Advantage Member: Any individual enrolled under the Senior Advantage Group Plan.

Member Rates: The amount that Health Plan would charge a Member for a medical Service or item if the Member's benefit plan did not cover the medical Service or item. Amounts paid as Member Rates for non-covered Services do not count toward payment of any Deductible. Health Plan determines the Member Rate by considering these factors:

- the cost of acquiring, storing, and/or dispensing the item;
- increases in the cost of medical and non-medical Services in Hawaii over the previous year;
- the relative difficulty of the medical Service compared to other medical Services;
- changes in technology; and
- payment for the medical Service under federal, state, or private insurance programs.

Monthly Premiums: The monthly membership charges paid by You (includes late charges). Monthly Premiums are in addition to any Cost Shares, in accordance with written notice from Us.

Non-Grandfathered Plan: A health insurance policy that effective after the Affordable Care Act (ACA) was signed into law on March 23, 2010, or a policy that existed before the ACA but lost its grandfathered status.

Medical Office Visits. Primary and specialty care visits at a Medical Office within the Service Area for evaluation and management which may include examination, history or medical decision. Office visits also includes consultations for surgical, obstetrical, pathological, radiological, or other medical conditions, as determined by a Physician.

Personal Care Physician (PCP): The term Personal Care Physician (PCP) means the Kaiser Permanente provider you choose to act as your personal health care manager.

Physician: Any doctor of medicine employed by Medical Group.

Prescriber: A practitioner licensed to prescribe drugs under state and federal law who (i) is designated by Health Plan and (ii) works in conjunction with Medical Group.

Rider: Enhanced coverage to this EOC.

Senior Advantage Evidence of Coverage: The document for Kaiser Permanente Senior Advantage members that is called the Kaiser Permanente Evidence of Coverage for Senior Advantage Members.

Service Area: The islands of Kauai, Lanai, Maui, Molokai, Oahu, and the Island of Hawaii.

Service(s): A treatment, diagnosis, care, procedure, test, drug, injectable, facility, equipment, item, or device.

Skilled Nursing Care: Skilled inpatient Services that are: (i) Medically Necessary, (ii) ordered by a Physician, (iii) customarily provided by Skilled Nursing Facilities, and (iv) above the level of custodial, convalescent or intermediate care.

Skilled Nursing Facility: An institution (or a distinct part of an institution) which: (i) provides 24-hour-a-day licensed nursing care; (ii) has in effect a transfer agreement with one or more hospitals; (iii) is primarily engaged in providing skilled nursing care as a part of an ongoing therapeutic regimen; (iv) is licensed under applicable state law; and (v) has been approved in writing by Medical Group.

Specialist: For the purpose of determining specialty or primary copays, a Specialist is a licensed medical practitioner identified by Health Plan or Medical Group, including a Physician, except does not include (i) family practice, (ii) general practice, (iii) internal medicine, (iv) pediatrics, (v) obstetrics/gynecology (including certified nurse midwives), and (vi) physician assistants (PA), and (vii) any Health Plan employed providers. Members must obtain a referral for most initial visits in order to receive covered Services from certain Specialists.

Spouse: Either a Subscriber's (i) legal husband or wife, or (ii) partner in a legal civil union.

Subscriber: A person (i) who meets all applicable eligibility requirements *Chapter 6: Membership Information* of this Guide; (ii) who is enrolled hereunder; and (iii) for whom the prepayment required in the Monthly Premiums section of this Guide has been received by Health Plan.

Urgent Care: When you require medical care for an expected illness or injury that is not an Emergency Medical Condition but cannot be reasonably postponed until your return to the Service Area.

We/Us/Our (lowercase we, us or our also have this same definition)**:** Kaiser Permanente.

You/Your (lowercase you or your also have this same definition)**:** You and/or your Family Dependents.

Important Numbers

Member Services

1-800-966-5955
TTY 711
Monday-Friday, 8 a.m. – 5 p.m.
Saturday, 8 a.m. - noon

24/7 Advice Line

1-833-833-3333
TTY 711

Appeals

1-800-966-5955
808-432-5260 (submit via Fax)

External Appeal

808-587-5379 (Fax Hawaii Insurance Commissioner)
808-586-2804 (Health Insurance Branch of the Hawaii Insurance Division)

Requests for Services or Supplies (Authorizations and Referrals Management)

808-432-5687
808-432-5691 (Fax)

Away from Home Travel (outside Hawaii)

1-951-268-3900

Claims Administration Member Services

1-877-875-3805

Language Assistance

1-800-966-5955

Pharmacy Services

808-643-7979

Patient Financial Services Department

Oahu: 808-432-5340
Neighbor islands: 1-888-597-5340

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