Kaiser Permanente Foundation Health Plan, Inc.

Kaiser Permanente Hawaii's Guide to Your Health Plan

Kaiser Permanente Group Plan

JANUARY 2023

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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	$2,500 per calendar year
Family Unit	13	$7,500 per calendar year (for 3 or more members)
Annual Deductible		
Member	14	None
Family Unit	14	None
Routine and Preventive		
Health Education and Disease Management		
• Medical Office Visits		
○ Primary Care	18	$20 per visit
○ Specialty Care	18	$20 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))	18	None
• Office Visit for (CDC) Immunizations	19	None
• Office visit for Travel Immunization		
○ Primary Care	19	$20 per visit
○ Specialty Care	19	$20 per visit
Medical Office Visits		
• Well-Child Care	19	None
• Annual Preventive Care (physical exam)	19	None
• Hearing Exam (for correction)		
○ Primary Care	19	$20 per visit
○ Specialty Care	19	$20 per visit
• Vision Exam (for glasses)		
○ Primary Care	19	$20 per visit

Description	Page #	Cost Share
○ Specialty Care	19	$20 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	$20 per visit
• Specialty Care	21	$20 per visit
Infertility Consultation		
• Primary Care	21	$20 per visit
• Specialty Care	21	$20 per visit
In Vitro Fertilization	21	20% of Applicable Charges
Maternity		
• Maternity Care – routine prenatal visits in Medical Office	23	None
• Maternity Care – delivery	23	20% of Applicable Charges
• Maternity Care – one postpartum visit in Medical Office	23	None
• Maternity and Newborn Inpatient Stay	23	20% of Applicable Charges
• Breast Pump	23	20% of Applicable Charges
Pregnancy Termination		
• Primary Care	23	$20 per visit
• Specialty Care	23	$20 per visit
• Total Care Settings	30	Included in Total Care Services
Voluntary sterilization (including tubal ligation)		

Description	Page #	Cost Share
• Medical Office	24	$20 per visit
• Total Care Settings	30	Included in Total Care Services
Special Services for Men		
Prostate Specific Antigen (screening)	24	None
Vasectomy		
• Primary Care	24	$20 per visit
• Specialty Care	24	$20 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	24	$20 per visit
• Specialty Care	24	$20 per visit
• Routine pre-surgical and post-surgical	24	None
Urgent Care Visits		
• Within Service Area	25	$20 per visit
• Outside Service Area	25	20% of Applicable Charges
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	$20 per visit
• Specialty Care	27	$20 per visit
Telehealth	27	Cost Share, if applicable, will vary depending on Service

Description	Page #	Cost Share
Laboratory, Imaging, and Testing		
Laboratory		
• Basic	27	$20 per day
• Specialty	27	20% of Applicable Charges
Imaging		
• General	28	$20 per day
• Specialty	28	20% of Applicable Charges
Testing		
• Allergy Testing		
○ Primary Care	28	$20 per visit
○ Specialty Care	28	$20 per visit
• Skilled-Administered Drugs	28	20% of Applicable Chares
• Diagnostic Testing	28	20% of Applicable Charges
Surgery		
Outpatient Surgery and Procedures		
• Primary Care	29	$20 per visit
• Specialty Care	29	$20 per visit
• Total Care Settings	30	Included in Total Care Services
Reconstructive Surgery		
• Primary Care	29	$20 per visit
• Specialty Care	29	$20 per visit
• Covered Mastectomy	29	20% 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	20% of Applicable Charges
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	31	20% of Applicable Charges
Emergency Services	31	20% of Applicable Charges
Observation	34	20% of Applicable Charges
Skilled Nursing Facility	34	20% of Applicable Charges for up to 120 days per Accumulation Period
Dialysis		
• Dialysis	35	20% of Applicable Charges
• Equipment, Training and Medical Supplies for home Dialysis	35	None
Radiation Therapy	35	20% of Applicable Charges
Ambulance		
Air Ambulance	35	20% of Applicable Charges
Ground Ambulance	35	20% of Applicable Charges
Physical, Occupational, and Speech Therapy		
Physical and Occupational Therapy		
• Medical Office	36	$20 per visit
• Home Health Care	36	None
• Total Care Settings	30	Included in Total Care Services
Speech Therapy		
• Medical Office	36	$20 per visit
• Home Health Care	36	None
• Total Care Settings	30	Included in Total Care Services
Home Health Care and Hospice Care		
Home Health Care	37	None

Description	Page #	Cost Share
Hospice Care	37	None
Physician Visits		
• Primary Care	37	$20 per visit
• Specialty Care	37	$20 per visit
Chemotherapy		
• Primary Care	38	$20 per visit
• Specialty Care	38	$20 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	38	None
• Total Care Settings	30	Included in Total Care Services
External Prosthetics Devices		
• Outpatient	39	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Braces		
• Outpatient	39	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Durable Medical Equipment		
Durable Medical Equipment		
• Outpatient	40	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Oxygen (for use with DME)		
• Outpatient	40	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Repair or Replacement		
• Outpatient	40	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
Diabetes Equipment	41	50% of Applicable Charges
Home Phototherapy Equipment	41	None
Behavioral Health – Mental Health and Substance Abuse		
Mental Health Care		
• Medical Office	41	$20 per visit
• Total Care Settings	30	Included in Total Care Services
Chemical Dependency Care		
• Medical Office	42	$20 per visit
• Total Care Settings	30	Included in Total Care Services
Autism Care		
• Primary Care	42	$20 per visit
• Specialty Care	42	$20 per visit
Transplants		
Transplant Care for Transplant Recipients		
• Primary Care	42	$20 per visit
• Specialty Care	42	$20 per visit
• Total Care Settings	30	Included in Total Care Services
Transplant Services for Transplant Donors (based on health plan approval)		
• Primary Care	43	$20 per visit
• Specialty Care	43	$20 per visit
• Total Care Settings	30	Included in Total Care Services
Related Prescription Drugs	44	See prescription drugs in this *Benefit Summary*
Transplant Evaluations		
• Primary Care	44	$20 per visit
• Specialty Care	44	$20 per visit
Prescription Drug		
Skilled Administered Drugs	44	20% of Applicable Charges; Included in Total Care Services

Description	Page #	Cost Share
Self-Administered Drugs	45	If your employer has purchased a drug rider, coverage will be as specified in your drug rider following this *Benefit Summary*
Chemotherapy Drugs		
• Chemotherapy Infusion or Injections (Skilled Administered Drugs)	45	20% of Applicable Charges
• Chemotherapy – Oral Drugs (Self-Administered Drugs	45	20% of Applicable Charges; or as specified in applicable drug rider
Contraceptive Drugs and Devices	45	50% of Applicable Charges
Diabetic Supplies	46	50% of Applicable Charges
Tobacco Cessation Drugs and Products	46	None (up to 30-day supply)
Drug Therapy Care		
Growth Hormone Therapy		
• Primary Care	46	$20 per visit
• Specialty Care	46	$20 per visit
• Skilled-Administered Drug	44	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Home IV/Infusion therapy		
• Therapy and IV drugs	47	None
• Self-administered injections	47	See prescription drugs in this *Benefit Summary*
Inhalation Therapy		
• Primary Care	47	$20 per visit
• Specialty Care	47	$20 per visit
• Total Care Settings	30	Included in Total Care Services
Miscellaneous Medical Treatments		
Blood and Blood Products		
• Medical Office	48	None
• Rh Immune Globulin	44	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
Dental Procedures for Children		
• Primary Care	48	$20 per visit
• Specialty Care	48	$20 per visit
• Total Care Settings	30	Included in Total Care Services
Hearing Aids		
• Hearing Test		
○ Primary Care	48	$20 per visit
○ Specialty Care	48	$20 per visit
• Appliances	48	60% of Applicable Charges
Hyperbaric Oxygen Therapy		
• Primary Care	48	$20 per visit
• Specialty Care	48	$20 per visit
• Total Care Setting	30	Included in Total Care Services
Materials for Dressings and Casts	49	Cost Share will vary upon place of service
• Total Care Setting	30	Included in Total Care Services
Medical Foods	49	20% of Applicable Charges
Medical Social Services	49	None
Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)		
• Primary Care	49	$20 per visit
• Specialty Care	49	$20 per visit
Pulmonary Rehabilitation		
• Primary Care	49	$20 per visit
• Specialty Care	49	$20 per visit
• Total Care Setting	30	Included in Total Care Services

ver. 1/2022

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 or partnership).

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), Group Agreement, 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 KP 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, out-of-area Urgent Care, or services covered under our Dependent Child out-of-area benefit from non-KP 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*.

The Kaiser Permanente Member Handbook provides further information about us including Member's Rights and Responsibilities. Please refer our Member Handbook by visiting 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 KP 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 KP 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. He or she 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 KP facility. A listing of KP 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 KP providers and in KP facilities within our Service Area except for these services:

- Written and authorized referrals (by a KP provider and/or our Authorizations and Referrals department)
- Emergency care
- Out-of-state Urgent Care when traveling
- Dependent child benefits (as described in this EOC) while out-of-state
- Other coverage which may have been purchased by your employer

Needing a Referral When Seeing a Specialist

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

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-KP providers or facilities. However, you must get prior authorization from us for Post-stabilization care from Non-KP providers and facilities.

"Post-stabilization care" means 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-KP specialty physicians and facilities who provide care when you are referred by your PCP should forward all claims to us. 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.** Female 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*.

Special provisions for Senior Advantage Members

Senior Advantage members should refer to their Senior Advantage Evidence of Coverage document for their coverage terms and Medicare benefits.

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 and Urgent Care only (and not follow-up care, routine care, and elective care) obtained outside our 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. You are responsible for paying the provider but may 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 or allied plan 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 temporarily 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 KP licensed health care practitioner,
- Is approved by the KP'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. 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 a 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 KP 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 KP 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 KP and you is made up of all of the following:

- This Kaiser Permanente Hawaii Guide to Your Health Plan
- Any riders and/or amendments
- The enrollment form submitted to us
- The agreement between KP and your employer or group sponsor (called the Group Agreement)

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 KP Hospital provides medical Services,
- The negotiated rate when a contracted non-KP provider or contracted non-KP facility provides medical Services, or
- The fee that we determine to be usual, reasonable and customary when a non-contracted non-KP provider or non-contracted non-KP 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 KP 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 KP. 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.

Medicare members will not pay more than the amount which Medicare rules and regulations allow.

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
- Dental services
- Dressings and casts
- Health education services, classes or support groups
- HMO Flex services
- 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 Accumulation Period 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 an Accumulation Period before KP will cover those Services. Once you meet the Annual Deductible, you are no longer responsible for deductible amounts for the remainder of the Accumulation Period, 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 Accumulation Period, 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 Accumulation Period. Once the Family Unit Deductible is satisfied, no further Member Deductibles will be due for the remainder of the Accumulation Period.

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

Amounts paid for covered Services that are received during the same Accumulation Period and that are subject to the Deductible as indicated by this EOC, count toward the 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 KP 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

Your employer or group sponsor must pay us amounts specified in the Group Agreement for each month on or before the agreed upon date, in the preceding month. Monthly Payments are subject to the terms in the Group Agreement between your employer/group sponsor and KP. 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.

Timely Payment

If your employer or group sponsor fails to pay Monthly Premiums on or before the due date, we may end coverage, unless all Monthly Premiums are brought current within 10 days of our initial written notice of default to your employer or group sponsor. We'll also provide written notice of intent to terminate on a specific date (and that the termination reason has been provided to your employer/group sponsor), at least 10 days prior to the specified cancellation date, to the State of Hawaii Department of Labor and Industrial Relations. We are not liable for benefits for Services received after the termination date. This includes benefits for Services you get if you are enrolled in this coverage under the provisions of the:

- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

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. (Exception: Senior Advantage appointments cannot be deferred due to outstanding balances.)

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. (Exception: Senior Advantage members cannot be charged for missed appointments.)

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 or out-of-area Urgent Care. 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.

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 Accumulation Period 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:

- 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, or your employer purchased coverage, 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:

- Breastfeeding 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 KP 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

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

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.*

Breast Pump

Covered (if your plan is a Non-Grandfathered Plan, or your employer purchased coverage) when prescribed by your treating provider, 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.

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 them other 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, or if your employer has purchased coverage, voluntary sterilization for female Members is covered at no charge in accordance with the ACA.

Special Services for Men

Prostate Specific Antigen (PSA) Screening

Covered, for screening laboratory test.

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

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 KP 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 KP at its 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) must notify the Health Plan office within 48 hours of any admission in order for care to be covered, otherwise payment for the claim may be denied.

No claim pursuant to this Urgent Care benefit is allowed unless a complete application for payment, on forms provided by Health Plan, is filed with the Health Plan office 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 Health Plan such consents, releases, assignments, and other documents as Health Plan 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 Permanente regions' service areas, at non-Kaiser Permanente facilities and with non-Kaiser Permanente health care providers.

- The Dependent Child must pay for services at the point in time services are received and 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 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,
- Death,
- 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, ear aches, 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:

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, 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, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient.

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).

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.

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-KP practitioner is not covered unless treatment meets the criteria for Emergency Services. Payment is limited to Emergency Services 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 KP at its 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 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 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) must notify the Health Plan office within 48 hours of any admission in order for care to be covered, otherwise payment for the claim may be denied.

No claim pursuant to this Emergency Services benefit is allowed unless a complete application for payment, on forms provided by Health Plan, is filed with the Health Plan office within 90 days after the first Emergency Service 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 Health Plan such consents, releases, assignments and other documents as Health Plan 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. 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 KP emergency departments 24 hours a day, seven days a week.

Once at the emergency room, 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 the physician or hospital to file a claim with us.

Emergencies Outside of Hawaii
For emergencies in another state or country, these guidelines apply:

- You are responsible for paying the provider directly and filing a claim with us. For more information on filing claims, see *Chapter 7: Filing Claims for Payment.*

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 contact KP 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

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.

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 care,
- 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 KP's 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 KP's 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 or by Medicare, 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

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.

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.

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.

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.

Braces

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.

Medical Equipment and Supplies

Durable Medical Equipment (DME)

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.

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 include 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

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 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 are 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 she or he 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 employer has purchased 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, or your employer purchased coverage, 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. 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 (for 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 (for Non-Grandfathered Plans). In addition to the coverage listed above, if your plan is a Non-Grandfathered plan, or your employer purchased coverage, 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

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.

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 of $5,500 per treatment phase.)

Pulmonary Rehabilitation

Covered, for prescribed pulmonary rehabilitation when preauthorized in writing by Kaiser Permanente. Your Cost Share for pulmonary rehabilitation is determined based on the location of your service. When provided in the Medical Office, pulmonary rehabilitation is provided upon payment of your office visit Cost Share. If you receive your pulmonary rehabilitation in one of our Total Care Service settings, then your covered pulmonary rehabilitation 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.

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.

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 employer may have purchased 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.

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.

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.

Clinical Trials:
For 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.

For Non-Grandfathered Plans, you are not covered for:

- the investigational service or item itself that is part of a covered clinical trial,
- 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.

Out-of-Area Dependent Child Coverage 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 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 or your employer made on an 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 or your employer 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.

Rehabilitation Programs: You are not covered for rehabilitation program Services, unless referred by a Physician.

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 maintain 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, except as covered by Medicare for Medicare Members.

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.

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.

Third Party Surrogacy Arrangement

A “Surrogacy Arrangement” 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 the names and addresses of the other parties to the Arrangement, and a copy of any contracts or other documents explaining the Arrangement, to:

Kaiser Permanente
711 Kapiolani Boulevard
Honolulu Hawaii 96813
Attention: Member Services

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 and incentives for participating in those programs, including completing health assessments or surveys.

Details concerning the offer of these extra services are expressed in a separate contract between Group and us.

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. The extra services described herein include services that are selected by the Group and others that are selected by you.

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 on 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
- Special Enrollments
- When Eligibility for Coverage Ends
- Conversion and Change of Residence
- Member Termination Provisions
- Continued Coverage

Eligibility

Individuals are accepted for enrollment and may continue coverage hereunder only if they meet all applicable requirements set forth in this EOC. In addition, Subscribers must live or work within the Service Area (Exception: Senior Advantage members must live within the Senior Advantage Service Area).

Subscribers

To be a Subscriber, a person on his or her own behalf and not by virtue of dependency status, must be either:

- An Employee of Group; or
- Entitled to coverage under a trust agreement, employment contract or retirement benefit program of Group.

All Subscribers must be currently enrolled hereunder, and prepayment required by *Chapter 2: Payment Definitions and Information* in this EOC, must have been timely made to us.

Family Dependents

To be an eligible Family Dependent, a person must be:

- 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.

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

Senior Advantage Member

To be a Senior Advantage Member, a person must meet all the following requirements (Family Dependents cannot be Senior Advantage Members unless they meet the following requirements in their own right):

- Meet the requirements for a Subscriber or Family Dependent in this EOC;
- Be entitled to benefits under both Medicare Parts A and B at the time of enrollment, unless the person was a Senior Advantage Member before 12/1/98;
- Reside in the Service Area;
- Be a United States citizen or are lawfully present in the United States;
- Not have end-stage renal disease (ESRD) at the time of enrollment, unless the person is a Member, or had ESRD while the person was a member of another Medicare Advantage plan that was terminated or not renewed on or after December 31, 1998, or who meets Centers for Medicare & Medicaid Services (CMS) waiver criteria for group enrollees with ESRD, and
- Be enrolled under the Senior Advantage plan.

Ineligible Persons

No person is eligible to enroll under this EOC if the person or any other person in his or her Family Unit has had entitlement to receive medical services through Kaiser Foundation Health Plan, Inc., terminated for any reason specified in the *Member Termination* Provisions section of this Chapter in this EOC.

Enrollment

Newly Eligible Persons

A person who newly attains eligibility to become a Subscriber may enroll by submitting an enrollment form to Group and Group submitting the completed enrollment form to Health Plan within 31 calendar days of Subscriber becoming eligible. If Health Plan fails to receive the completed enrollment form within 31 calendar days from the date the Subscriber is newly eligible, the Subscriber's effective date will begin the first day of the month following the date Health Plan receives the completed enrollment form from Group.

If Group has a probationary period during which a new Employee may not enroll, the enrollment form must be submitted to Group within 31 calendar days after the probationary period ends.

If Subscriber desires to enroll the persons then eligible to become the Subscriber's Family Dependents, they must be enrolled at the same time as Subscriber.

Any newborn or adopted child who newly attains eligibility to become a Family Dependent may be enrolled by Subscriber submitting a change of enrollment form to Group and Group submitting the completed enrollment form to Health Plan within 31 calendar days of the newborn's birth, or adopted child being placed for adoption. Placement occurs when Subscriber assumes legal obligation for total or partial support of the child in anticipation of the adoption.

If Health Plan fails to receive the completed enrollment form within 31 calendar days of the newborn's birth, or the child being placed for adoption, the newborn or adopted child may not be enrolled until the Group's next open enrollment period.

If CMS confirms a Senior Advantage Member's enrollment and effective date, Health Plan will send the Member a notice that confirms the enrollment and effective dates. If CMS tells Health Plan that the Member does not have Medicare Part B coverage, Health Plan will notify the Member of disenrollment from Senior Advantage.

Any other person who newly attains eligibility to become a Family Dependent, such as a new Spouse, may be enrolled by Subscriber submitting a change of enrollment form to Group and Group submitting the completed enrollment form to Health Plan within 31 calendar days of the person newly attaining eligibility. If Health Plan fails to receive the completed enrollment form within 31 calendar days from the date the person is newly eligible, that person may not be enrolled until the Group's next open enrollment period.

A newborn child of a Family Dependent other than the Subscriber's Spouse may be enrolled only if the newborn child meets the eligibility requirements of a Family Dependent of this EOC. A child to be adopted by Subscriber may be enrolled only if the child meets the eligibility requirements of a Family Dependent of this EOC.

Open Enrollment Period

Eligible persons not enrolled when newly eligible as specified above may be enrolled as Subscribers and Family Dependents only during the Group's open enrollment period specified by the Group or mentioned in the Group Agreement, by submitting an enrollment form to Group.

Special Enrollment

The only exceptions where eligible persons may be allowed to enroll outside of the open enrollment period are if:

- Such person waived medical coverage when first eligible and Group does not give us a written statement that verifies such person signed a document that explained restrictions about enrolling in the future, or
- Such person waived medical coverage when first eligible because he/she had other coverage that met the requirements of state law, and such person's waiver terminates before the next open enrollment period or such person informs us in writing that he/she does not want to continue the waiver past the end of the current Accumulation Period,

- Such person qualifies for an exemption from medical coverage under state law and the exemption ends before the next open enrollment period, or
- For reasons specified in the Special Enrollment section later in this chapter.

Limitation on Enrollment

If the Kaiser Permanente Senior Advantage Plan has reached its capacity limit that the Centers for Medicare & Medicaid Services has approved, Members that meet the eligibility enrollment provisions may be ineligible to enroll as Senior Advantage members.

Effective Date of Coverage

Newly Eligible Persons

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 which the Group receives 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.

Open Enrollment Period

Coverage for persons enrolled during an open enrollment period is effective on the date specified by the Group or as listed in the Group Agreement.

Special Enrollment

Coverage for persons enrolled outside of the open enrollment period is effective on the date specified by the Group or as listed in the Group Agreement.

Special Enrollments

Special Enrollment Due to Newly Eligible Family Dependents

A person may enroll as a Subscriber (along with any or all eligible Family Dependents), and existing Subscribers may add any or all eligible Family Dependents, within 31 calendar days after marriage or civil union, birth, adoption, or placement for adoption by submitting a change of enrollment form to Group and Group submitting the completed enrollment form to us within 31 calendar days after a Family Dependent become newly eligible.

Effective date of an enrollment resulting from marriage or civil union is no later than the first day of the month following the date Group receives an enrollment form from the Subscriber, subject to the restrictions listed in the Enrollment section of this chapter. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

Special Enrollment Due to Loss of Other Coverage

A person may enroll as a Subscriber (along with any or all eligible Family Dependents), and existing Subscribers may add any or all eligible Family Dependents, by submitting an enrollment form to Group and Group submitting the completed enrollment form to Health Plan within 31 calendar days after such person loses other coverage if:

- Subscriber or at least one of the Family Dependents had other coverage when he or she previously declined coverage, and
- the loss of other coverage is due to one of the following:
    - exhaustion of COBRA coverage
    - termination of employer contributions for non-COBRA coverage
    - loss of eligibility for non-COBRA coverage, but not termination for cause from a Kaiser Permanente health plan for reasons specified in the Termination for Cause section of this chapter, or termination from Kaiser Permanente for Individuals and Families (nongroup) plan for nonpayment,
    - loss of eligibility for Medicaid coverage or CHIP coverage, but not termination for cause,
    - loss of eligibility for coverage under any other health insurance, public assistance or prepaid health plan described in HRS §393-17, or
    - reaching a lifetime maximum on all benefits.

Note: If a person is enrolling as a Subscriber with at least one eligible Family Dependent, only one person must meet the requirements stated above.

A person requesting enrollment resulting from loss of Medicaid cover or CHIP coverage must submit an enrollment form to Group and Group must submit the completed enrollment form to us within 60 calendar days after such person loses Medicaid or CHIP coverage,

Effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date that Group receives an enrollment or change of enrollment form from the Subscriber.

Special Enrollment Due to Court or Administrative Order

Subscriber may add a Family Dependent if required by court or administrative order to provide medical coverage for a Spouse or child who meets the eligibility requirements as a Family Dependent by submitting an enrollment or change of enrollment form to Group and Group submitting the completed enrollment form to Health Plan.

Effective date for enrollment resulting from a court or administrative order will be determined by Group, except no earlier than the date of the order, and no later than the first day of the month following the date of the order.

Special Enrollment Due to Eligibility for Premium Assistance under Medicaid or CHIP

A person may enroll as a Subscriber (along with any or all eligible Family Dependents), and existing Subscribers may add any or all eligible Family Dependents, if Subscriber or at least one of the enrolling Family Dependents becomes eligible for premium assistance under Medicaid or CHIP, by submitting an enrollment or change of enrollment form to Group and Group submitting the completed enrollment form to Health Plan within 60 calendar days after Subscriber or Family Dependent is determined eligible for premium assistance.

Effective date of an enrollment resulting from eligibility for premium assistance under Medicaid or CHIP is no later than the first day of the month following the date Group receives an enrollment form from the Subscriber.

Special Enrollment Due to Reemployment After Military Service

If you terminate coverage due to a call to active duty in the uniformed services, you may be able to reenroll upon reemployment by your Group, in accordance with applicable laws. You should contact your Group for more information.

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 at the end of the month in which any of the following events take place:

- For you, when you choose to terminate coverage under this EOC by giving us 31 calendar days written notice prior to the termination date;
- For Groups, when Subscriber retires, fails to meet the eligibility criteria in the Eligibility section in this chapter, terminates employment with Group, or otherwise severs relationship with Group, then membership for Subscriber and Subscriber's Family Dependent Members is terminated;
    - Retroactive termination and prior written notice to Senior Advantage members. In accord with the Centers for Medicare & Medicaid Services (CMS) requirements, Senior Advantage members must receive 21 days prior written notice before their membership terminates. This means that Group may not retroactively terminate Senior Advantage membership. In addition, Group must provide Health Plan 30 days prior written notice

of Senior Advantage involuntary membership terminations. The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage disenrollment form unless Group specifies a later termination date. For example, if Health Plan receives a termination notice on March 5 for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

  - Note: If we receive a disenrollment notice from CMS or the Member, the effective date of membership termination will be in accord with that notice and CMS requirements.
  - Group must send membership changes to the following address:

    Kaiser Permanente Membership Administration
    P.O Box 203011
    Denver, CO 80220-9011

- for Subscriber's Spouse, upon termination of or from Subscriber's coverage or upon dissolution of the marriage or civil union;
- for other Family Dependents, upon termination of or from Subscriber's coverage or when a Family Dependent fails to meet the eligibility criteria in the Eligibility section in this chapter.

You must promptly inform Group, and Group must promptly inform us, in writing, when you no longer meet the requirements in the Eligibility section in this chapter.

Eligibility will also terminate upon the termination of the Group or the Member, for any of the termination reasons described in the Member Termination Provisions section of this chapter or Group termination provisions in the Group Agreement. The process will be as described within those provisions.

Conversion and Change of Residence

Conversion to Non-Group Membership

A person residing in the Service Area may convert to non-Group membership within 30 calendar days after membership under this EOC ("Group Membership") terminates, by submitting a signed enrollment form to Health Plan with prescribed prepayment unless:

- Member does not meet the non-Group plan eligibility criteria, or
- Group membership terminates under the *Member Termination Provisions* section of this chapter, or *Group Termination Provisions* section in the Group Agreement. (Members who are terminated for non-payment) may convert to non-Group membership only if Monthly Premiums payments are made within 10 calendar days of notice of cancellation), or
- Member continues to be eligible for coverage under Group, or
- This EOC between Group and Health Plan ends.

Non-Group membership begins when the applicant has been accepted for enrollment as a non-Group Member, and the applicant has prepaid amounts required for the non-Group membership. The effective date of coverage will be in accord with Health Plan's special enrollment period dates. Covered medical services, Deductibles, Cost Shares and other provisions under non-Group membership may

differ from those provided under this EOC. Any person interested in conversion to non-Group membership should contact the Health Plan Member Services immediately upon notice of any termination, for application forms, procedures and pre-payment information regarding conversion.

Change of Residence – General (for All Members except Senior Advantage Members)

We may terminate the membership of any Member who moves outside the Service Area in accord with *the Member Termination Provisions* section of this chapter, or *Group Termination Provisions* section in the Group Agreement. The only benefits covered by this Guide outside the Service Area prior to termination of membership are Emergency Services specified in the *Emergency Services and Urgent Care* sections in *Chapter 3: Benefit Description* in this Guide.

Senior Advantage Members

Senior Advantage Members may be temporarily out of the Senior Advantage Service Area for up to 6 months. Members may only receive benefits outside the Service Area as specified in the section Emergency and Urgent Care sections of their Kaiser Permanente Senior Advantage Evidence of Coverage.

Senior Advantage Members who permanently move out of the Senior Advantage Service Area, or are absent from the Senior Advantage Service Area for a period longer than 6 months, may not continue their Senior Advantage membership. Such a Member must give us written notice of the move. We will terminate such a Member in accord with the Termination for Move Outside the Service Area by Senior Advantage Members section of this chapter.

Senior Advantage Members may be able to continue Kaiser Foundation Health Plan membership if they permanently move to another Kaiser Foundation Health Plan service area. Senior Advantage Members must apply at a Kaiser Foundation Health Plan office in that service area. Benefits and membership charges in the new Region may not be the same as under this EOC. Senior Advantage Members should contact their Group to determine if coverage through their Group is available in other Kaiser Foundation Health Plan service areas.

Member Termination Provisions

The term of this EOC continues in effect for one year from the effective date stated on the Group Agreement, unless terminated otherwise as set forth in the *Group Termination Provisions* in the Group Agreement. This EOC does not automatically renew.

When Health Plan terminates your membership, neither Health Plan, Hospitals, Medical Group, nor any KP provider has any further liability or responsibility under this EOC, for any Services obtained after the Member's termination date except under sections titled Return of Pro Rata Portion of Monthly Premiums; and Inpatient Care for Senior Advantage Members after Termination. 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.

Termination for Cause

- **Disruptive, Unruly or Abusive Behavior.** If you are (i) violent, disruptive, unruly, abusive, or uncooperative to the extent that the ability of Health Plan, Hospitals or Medical Group to provide medical services to you or other Members is seriously impaired, (ii) your conduct seriously threatens the safety or property of others, or (iii) if Medical Group is unable to establish and maintain a satisfactory Physician-patient relationship with you, after reasonable efforts to do so, then we may terminate your membership and all other Members in your Family Unit (unless a Member in the Family Unit is a Senior Advantage Member) upon 15 calendar days written notice to Subscriber, may pursue 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. This termination provision will apply to a Subscriber enrolled on a Subsection A plan if Kaiser Permanente is a single choice carrier (i.e. Kaiser Permanente is the only medical plan offered by the employer). For Senior Advantage Members, only (i) is applicable and requires prior CMS approval.
- **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. You must advise us of any change in family status or Medicare coverage status that affects eligibility or benefits. If you (or anyone acting on your behalf) knowingly furnish incorrect or incomplete material information, fail to inform us of a material change in family or Medicare coverage status, or have committed fraud in connection with membership, we may retain your membership card and terminate your membership and the membership of all the other Members in your Family Unit (unless a Member in the Family Unit is a Senior Advantage Member) 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 (unless a Member in the Family Unit is a Senior Advantage Member) upon 30 calendar days written notice to the Subscriber.
- **Additional Termination Provision for Senior Advantage Members.** We may terminate the membership of Senior Advantage members who do not stay continuously enrolled in both Medicare Part A and Part B.
- **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.

We may terminate the membership of a Senior Advantage Member under this paragraph in accord with Senior Advantage guidelines only if that Member fails to timely pay any Monthly Premiums he or she owes.

After the effective date of termination, membership may be reinstated only by:

- Payment of all past amounts due as permitted by applicable law, and
- Reapplication and re-enrollment in accord with *Open Enrollment Period* section of this EOC.

Services received after the effective date of termination will be charged at full charges.

Termination for Move Outside the Service Area by Senior Advantage Members

- **Permanent Move.** If a Senior Advantage Member permanently moves from the Service Area, we will terminate the membership of the Member upon verification of the permanent move. If that Senior Advantage Member is the Subscriber, then we will terminate all Members in the Family Unit. Services received after the effective date of termination will be charged at full charges.
- **Absences exceeding six months.** If a Senior Advantage Member is outside the Service Area for longer than 6 months, we will terminate the membership of the Member at the end of the sixth month. If that Senior Advantage Member is the Subscriber, then Health Plan will terminate all Members in the Family Unit. Services received after the effective date of termination will be charged at full charges.

Termination for Move Outside of the Service Area (for All Members Except Senior Advantage Members)

We may terminate the membership of a Member covered under this EOC upon 15 calendar days prior written notice to Subscriber if a Member moves outside the Service Area. A termination of the Subscriber's membership also terminates the membership of all Family Dependents.

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.

Return of Prorata Portion of Monthly Premiums

If we terminate the membership of a Member under the *Member Termination Provisions* section, within 30 calendar days Health Plan will pay the following amounts, less any amounts due by the Member to Health Plan, Hospitals or Medical Group:

- Payments made by Group on behalf of the terminated Member applicable to periods after the effective date of termination; and
- Any amount determined by us to be due on claims while the person was a Member.

Termination of Contract with CMS

Termination of the membership of specific Senior Advantage Members for any reason specified in the Group Termination Provisions section of the Group Agreement is governed by federal regulations which must be observed by Health Plan and Senior Advantage Members. Explanation is given in their Kaiser Permanente Senior Advantage Evidence of Coverage.

If the Medicare Advantage contract between Health Plan and CMS ends, Senior Advantage Members may continue their Health Plan membership under another coverage available to Members with Medicare benefits. Such coverage will begin when the contract between Health Plan and CMS ends.

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 Conversion, Change of Residence and ERISA sections of this EOC, the Arbitration sections of this EOC, and this Member Termination Provisions section of this EOC.

Inpatient Care for Senior Advantage Members after Termination

If coverage under Kaiser Permanente Senior Advantage ends while the Member is an inpatient in a hospital which Original Medicare would pay under the Prospective Payment System (PPS), Kaiser Permanente Senior Advantage is responsible for the inpatient facility services until the date of the Member's discharge. Kaiser Permanente Senior Advantage is not responsible for services, other than inpatient hospital services, furnished on or after the effective date of your disenrollment.

Involuntary Membership Termination of Senior Advantage Members

In accord with the Centers for Medicare & Medicaid Services (CMS) requirements, the effective date of Senior Advantage involuntary membership termination is the first of the month following 30 days after

the date when we receive a Senior Advantage disenrollment form unless Group specifies a later termination date. For example, if we receive a termination notice on March 5 for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Monthly Premiums for the months of March and April.

Note: If we receive a disenrollment notice from CMS or the Member, the effective date of membership termination will be in accord with that notice and CMS requirements.

Group must send membership changes to the following address:

Kaiser Permanente Medicare Department
P.O Box 232407
San Diego, CA 92193-9914

Continued Coverage

COBRA

You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law (the Consolidated Omnibus Budget Reconciliation Act). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and monthly payments may change, and where to send your monthly payments. We may terminate your COBRA coverage if we do not receive your monthly payments, or for any reason allowed under this EOC or under federal COBRA law.

Continuation Coverage Under Federal Uniformed Services Employment and Reemployment Rights Act (USERRA) Law

If you are called to active duty in the uniformed services, you may be able to continue coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 calendar days after your call to active duty. You should contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

Chapter 7: Filing Claims for Payment

- Claims for Payment or Reimbursement (Services from Non-KP providers)
- How to File Claims
- Claims Decisions
- Requests for KP Services or Supplies You Have Not Received

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

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

- Written and authorized referral (by a KP provider and/or our Authorization and Referrals department)
- Out-of-state urgent care when traveling
- Dependent child benefits (as described in this guide) while out-of-state.
- Other coverage which may have been purchased by your employer.

In most cases, the Non-KP provider will submit a claim form and itemized statement describing the services received on your behalf. The Non-KP Provider's statement needs to include itemized statements describing services received. We review and authorize claim(s) after the services have been provided, not during an Emergency or urgent episode. If you, your family members, or providers call us during an Emergency or urgent episode, we'll confirm your membership status. However, we will not authorize coverage or payment at that time.

How to File Claims

In some cases, 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 KP Claims address **within 90 days** (or as soon reasonably possible) after services were received.

KP 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 KP 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 he or she 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**.

Claims Decisions

Our standard decision will be made within 30 calendar days from the date we receive your post-service claim for payment. If we don't have sufficient information to make a decision, we'll send you a written notice about the next steps available to you. If we determine that your claim is not covered, we'll send you a denial notice, which will include the specific reason for the denial, refer to the health plan provisions on which our denial is based, and state your appeal rights. If you disagree with our denial decision, you can file an appeal by following the appeal procedures described in *Chapter 8: Dispute Resolution*.

Upon written request to the address listed in the "Standard decision" section under the "Requests for services or supplies you have not received" later in this section, you may be provided a free copy of all documents and information relevant to your request for payment or coverage; 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 also have the right to request the diagnosis and treatment codes and their meanings that are the subject of your claim for coverage or payment. 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.

Requests for Kaiser Permanente Services or Supplies You Have Not Received

Standard Decision

You, your authorized representative, or treating Physician may request that we provide health care services or supplies you have not received but believe you're entitled to receive through Kaiser Permanente. These requests should be submitted in writing to the following address:

Kaiser Foundation Health Plan, Inc.
Authorizations and Referrals Management
2828 Paa St.
Honolulu, HI 96819
808-432-5687 (Oahu and the neighbor islands)

Your written submission should include your name, the authorized representative's name if applicable, your medical record number, the specific service or supply you're requesting, and any comments, records, or other information you think is important for our review. We have the right to require that you provide all documents and information that we deem necessary to make a decision. If you don't provide any information requested in regard to any request for coverage, claim for payment, or related appeal, or if the information you provide does not show entitlement to the coverage or payment you request, this could result in an adverse decision.

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

Our standard decision will be made within 14 calendar days from the date we receive your non-urgent pre-service request. If we cannot make a decision on your request within the standard allotted time because we don't have sufficient information or because of other special circumstances, within the 14 calendar days, we'll send you a written notice of the circumstances requiring an extension of time and the date by which we expect to render a decision. If we determine that your request is not covered, we'll send you a denial notice, which will include the specific reason for the denial, refer to the health plan provisions on which our denial is based, and your appeal rights. If you disagree with our denial decision, you can ask us to reconsider our decision by filing an appeal. *See Chapter 8: Dispute Resolution.*

Expedited Decision

You, your authorized representative, or treating Physician may ask that we decide your request on an expedited basis if we find, or if your health care provider states, that waiting for a standard decision could seriously affect your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed.

You, your authorized representative, or treating Physician may request an expedited decision anytime by calling **808-432-5687**, or by faxing, writing, or delivering your request to the same address listed for standard decisions. Our fax number is **808-432-5691**. The fax number for appeals is listed in *Chapter 8: Dispute Resolution*.

Specifically state that you want an expedited decision. If we have all the information we need to make a decision and your request qualifies for expedited review, then we'll give our decision to you orally or in writing within 72 hours of our receipt of your request. If we gave you our decision orally, then we must send you written confirmation within three calendar days following our oral notice.

We will decide your request within 24 hours if we have all the information we need to make a decision when your request relates to an ongoing (sometimes called "concurrent") course of treatment that is being terminated or reduced and you make your request for continued coverage within 24 hours before the services are scheduled to end.

If your request qualifies for expedited review but you don't provide us with sufficient information to determine coverage, we'll inform you within 24 hours of our receipt of your request and give you at least 48 hours to provide us with the specified information. If we decide that your request is not covered, we'll send you a denial notice, which will include the reason for the denial and your appeal rights. If you disagree with our decision, you can ask us to reconsider our decision by filing an appeal, using the appeal procedures described in *Chapter 8: Dispute Resolution*.

You may appoint someone to file your expedited request on your behalf by following the steps described earlier in the "Standard decision" section. If a health care provider with knowledge of your condition makes a request for an expedited decision on your behalf, we don't require you to appoint your health care provider in writing.

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 can also find additional information about the appeal process in your Member Handbook. 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 he or she 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 96814

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, Kaiser Permanente Medicare Cost, Kaiser Permanente QUEST Integration, the Federal Employees Health Benefits Program, and Kaiser Permanente Individuals and Families. Members on these plans should consult their respective Evidence of Coverage, handbook, 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). The process is available for decisions about medical judgment including one based on our requirements for medical necessity, appropriateness, health care setting, level of effectiveness of care for a covered service, or our determination that the requested care or service is experimental or investigational. 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, handbook, 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).
- claims that may not be subject to binding arbitration under applicable federal or state law ;
- for Medicare members, claims subject to the Medicare appeals process.

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 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 the "Initiating arbitration" section.

Benefit Claims

If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may pursue legal action in federal or state court, as appropriate, after the Member Party has exhausted the claims and appeals process and, if applicable, external review process. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact Health Plan at 1-800-966-5955.

Although benefit-related claims may not be required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the "Initiating Arbitration" section. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to this "Dispute Resolution" 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 process 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.

Senior Advantage Member Claims

Complaints and appeals procedures for Senior Advantage Members are described in the Kaiser Permanente Senior Advantage Evidence of Coverage (EOC). The arbitration provisions of this EOC apply only to Senior Advantage Member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this EOC, irrespective of the legal theory upon which the claim is asserted.

Chapter 9: Coordination of Benefits

- Coordination of Benefits
- If You are Hospitalized When Coverage Begins
- Medicare
- Third Party 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

If You are Eligible for Medicare as primary coverage

If you are eligible for Medicare as primary coverage, your Basic Premiums are based on the assumption that we, or our designee will receive Medicare payments for Medicare-covered services provided to you eligible for benefits under Medicare Part A or Part B (or both). If you are or become eligible for Medicare as primary coverage, you must comply with all of the following requirements:

- Enroll in all parts of Medicare for which the Member is eligible and continue that enrollment while a Member.
- Be enrolled through Member's Group in Kaiser Permanente Senior Advantage.
- Complete and submit all documents necessary for us, or any provider from whom you receive medical services covered by us, to obtain Medicare payments for Medicare-covered services provided to you.

If you do not comply with all of these requirements for any reason, even if you are unable to enroll in Kaiser Permanente Senior Advantage because you do not meet our eligibility requirements, our insurance plan is not available through your Group, or Senior Advantage is closed to enrollment, we will increase your Group's Basic Premiums to compensate for the lack of Medicare payment and transfer your membership to our

non-Medicare plan if you are not already so enrolled. However, if your Group does not pay us for the entire Monthly Premiums required for your Family Unit, we will terminate the memberships of everyone in your Family Unit in accord with the Termination of Membership section of this EOC.

Member with Medicare and Retirees

This plan is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this EOC, you are or become eligible for Medicare or you retire, you should ask your Group's benefits administrator about your membership options as follows:

- If a Subscriber retires who is entitled to Medicare Parts A and B, and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber could enroll in the Kaiser Permanente Senior Advantage plan if eligible.
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as a non-Group Kaiser Permanente Senior Advantage Member (all eligibility criteria must be met for the non-Group Kaiser Permanente Senior Advantage plan).
- If federal law requires that your Group's health care plan be primary and Medicare coverage be secondary, your coverage under this EOC will be the same as it would be if you had not become eligible for Medicare. However, you may be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you are entitled to Medicare Parts A and B.
- If you are, or become eligible for Medicare and are in a class of beneficiaries for which your Group's health care plan is secondary to Medicare, you should enroll in Kaiser Permanente Senior Advantage through your Group if eligible.
- If none of the above applies to you, and you are eligible for Medicare or you retire, you should ask your Group's benefits administrator about their membership options.

When Medicare is Primary

If you are or become eligible for Medicare Part A or Part B (or both), as primary coverage, and are not enrolled through your Group in Kaiser Permanente Senior Advantage plan for any reason (even if you are not eligible to enroll or our plan is not available to you), your Group's Basic Premiums may increase. If your Group fails to pay the entire Monthly Premiums required for your Family Unit, we will terminate the membership of everyone in your Family Unit in accord with the *Termination for Nonpayment* section in *Chapter 6: Membership Information* of this EOC.

When Medicare is Secondary

Medicare is the primary coverage except when federal law requires that your Group's health care plan be primary and Medicare coverage be secondary. Members eligible for Medicare as their secondary coverage are subject to the same Monthly Premiums and receive the same benefits as Members who are not eligible for Medicare.

However, Members who meet the eligibility requirements for the Kaiser Permanente Senior Advantage plan may enroll in Senior Advantage if the plan is available to them. These Members receive the benefits and coverage described in the Kaiser Permanente Senior Advantage Evidence of Coverage (EOC).

Third Party Liability

If You Have Coverage Under Worker's Compensation

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:

Kaiser Foundation Health Plan, Inc.
711 Kapiolani Boulevard
Honolulu, Hawaii 96813

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
- ERISA 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.

Confidentiality for us and your Group

We and your Group shall comply with all federal and state laws, rules and regulations regarding the confidentiality of protected health information pertaining to you or to persons seeking eligibility to Group's Plan, and shall not use or disclose such information except as permitted or required by federal or state laws, rules or regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Group's duties of confidentiality shall extend to protect health information learned about its Members arising from Group's role as Plan Administrator. We shall protect the confidentiality of Group's propriety business information marked as "Confidential and Proprietary" by not disclosing such information to persons outside of Health Plan, except as required by law.

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. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose certain PHI to them, such as information regarding health plan eligibility or payment, or regarding a workers' compensation claim. 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.

ERISA Information

Group is the Plan Administrator of this employee benefit plan for purposes of the Employee Retirement Income Security Act of 1974 (ERISA). Group agrees to prepare and distribute to all Members a Summary Plan Description describing the terms, benefits and conditions of the employee benefit plan, in compliance with ERISA requirements. Group agrees to inform Members of all information required by ERISA.

Group agrees to take all other necessary and appropriate actions as a Plan Administrator and fiduciary under ERISA.

We and your Group are fiduciaries under this EOC. The Group is responsible for all Plan Administrator and other duties under ERISA, not expressly assumed by us under this EOC. We are a named fiduciary to adjudicate health benefit claims relating to coverage under this EOC, but have not agreed to accept any other fiduciary responsibility.

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.

Group as Agent for You

By requesting and accepting membership under the Group's EOC with Health Plan, you authorize Group to act as agent for you for purposes of entering into this EOC and for all other purposes in regards to this EOC. Any notice to Group by Health Plan is deemed notice 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 Group or 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, Member Handbook 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.

Compliance with Laws

We and your Group 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. Group shall also be solely responsible for compliance with all requirements of ERISA Plan Administrator as defined under ERISA, and all requirements of the Hawaii Prepaid Health Care Act, except those requirements expressly imposed by those laws solely upon Health Plan. Group shall also be responsible for compliance with applicable requirements under the Patient Protection and Affordable Care Act and related federal health care reform laws and regulations, except those requirements expressly imposed by those laws upon Health Plan. We will provide Group with a summary of benefits and coverage (SBC) for each Health Plan non-Medicare coverage that is included in this EOC. Group will provide electronic or paper SBCs to participants and beneficiaries to the extent required by the Patient Protection and Affordable Care Act, except that we will provide SBCs to Members who make a request to us.

EOC Binding on Members

By this EOC, Group makes Health Plan coverage available to persons who are eligible. However, this EOC is subject to amendment, modification or termination in accord with any provision hereof or by mutual agreement between us and Group without your consent or concurrence. Group is contracting on behalf of you (you are not contracting with us), but by electing medical and hospital coverage pursuant to this EOC, or accepting benefits hereunder, you agree to all terms, conditions and provisions of this EOC. 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.

EOC Implementation

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

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 he or she is 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.

If to Group:

To the latest address provided by Group.

For notices from Group to Subscribers: A person designated by Group by written notice to us shall disseminate notice to Subscribers by the next regular communication to them but in no event later than 30 calendar days after receipt thereof, of all matters (of which Group Representative receives notice from us) to which a reasonable person would attach importance in determining the action to be taken upon the matter.

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 Group or 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 and Senior Advantage Members

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

Chapter 11: Glossary

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

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

Accumulation Period: An Accumulation Period is a calendar year. However, it may be another period of at least twelve (12) months if Group has made such an agreement in writing with Health Plan. Members may contact their Group or the Member Services to find out if their Group has agreed upon an Accumulation Period other than a calendar year.

Annual Copayment Maximum: The Annual Copayment Maximum is the maximum Cost Share 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.

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 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 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, 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.

Medicare members will not pay more than the amount which Medicare rules and regulations allow.

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.

COBRA: The Consolidated Omnibus Budget Reconciliation Act, which provides certain rights for continuation of coverage when Group membership is lost due to certain events.

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 an Accumulation Period before KP will cover those Services. Once you meet the Annual Deductible, you are no longer responsible for deductible amounts for the remainder of the 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.

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 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

Employee: (1) A person employed in the employment of Group for at least twenty (20) hours per week in Hawaii, and has been in employment of the Group for at least four (4) consecutive weeks, or (2) if Group is a health and welfare plan established or maintained pursuant to collective bargaining agreements, "employee" means a person who satisfies all Group-defined employment eligibility requirements.

ERISA: The Employee Retirement Income Security Act of 1974, which provides certain rights to Health Plan Members who are employed by private employers. ERISA does not apply to Health Plan Members who are employed by a governmental employer.

Evidence of Coverage (EOC): This Kaiser Permanente Hawaii Guide to your Health Plan (Guide), Group Agreement, Riders, 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 (Note: the term Family Unit does not apply to the Kaiser Permanente Senior Advantage Plan).

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.

Group: (1) The organization that meets the Prepaid Health Care Act's definition of employer, and that can show proof of an active Hawaii Department of Labor account number, and which is identified as the Group in this EOC, including all Subscribers and Family Dependents who are part of the Group Agreement between Group and Health Plan, or (2) if the Employee receives medical services and benefits under this EOC through a health and welfare plan, "Group" means the aforesaid health and welfare plan which is identified as the Group in this EOC.

Group Agreement: The Agreement between KP and your employer or group sponsor.

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.

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 KP licensed health care practitioner,
- Approved by the KP'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 Group (includes late charges, and any charges referred to in the Medicare section of *Chapter 9: Coordination of Benefits*).

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.

Non-Grandfathered Plan: A health insurance policy that became 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.

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 KP 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, except for Senior Advantage whose service area does not include the islands of Kauai, Lanai, and Molokai and zip codes 96718, 96772. and 96777 for 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 by 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 life threatening but cannot be reasonably postponed until your return to the Service Area.

We/Us/Our: Kaiser Permanente.

You/Your: 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

Oahu: 808-432-2000
Maui/Molokai/Lanai: 808-243-6000
Hawaii Island: 808-334-4499
Kauai: 808-246-5600
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

1-800-966-5955

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

rev. 1/2022