KAISER PERMANENTE®

Citigroup

Hawaii
HMO
Group #996

Effective Dates: 1/1/2013 – 12/31/2013

General Information	
Website	my.kp.org/citigroup
Member Services Number	432-5955 (Oahu), 1-800-966-5955 (Neighbor Islands)
Member Services Weekday Hours	8 a.m. to 5 p.m.
Member Services Weekend Hours	Saturday: 8 a.m. to noon Sunday: Closed
Annual Deductible: Individual/Family	None
Annual Out-of-Pocket Max: Individual/Family	$2,000 (Individual) $6,000 (Family)
Office Visits (Outpatient)	
Primary Care	$15 copay per visit
Specialty Care	$15 copay per visit
Preventive Care(1)	No charge
Scheduled Prenatal Visits and 1st Postpartum Visit	$15 copay for initial visit to confirm pregnancy
Well-Baby Care (18 months or younger)(2)	No charge
Vision Exam - Optometrist	$15 copay per visit
Vision Exam - Ophthalmologist	$15 copay per visit
Physical, Occupational, Speech Therapy	$15 copay per visit
Outpatient/Ambulatory Surgery	$15 copay per visit
Lab and X-Ray (Outpatient)	
Laboratory	$15 copay per department per day
X-Ray	$15 copay per department per day
MRI/CT/PET/Nuclear Medicine	$15 copay per department per day
Emergency Care	
Ambulance (Ground or Air)	No charge
Emergency Room (Worldwide)	$50 copay per visit
Urgent Care	$15 copay per visit at a Kaiser Permanente facility within the Hawaii service area; 20% of applicable charges at a non-Kaiser Permanente facility outside the Hawaii service area
Hospital Care (Inpatient)	
Inpatient	No charge
Delivery and Inpatient Baby Care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to your Evidence of Coverage.

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Mental Health and Chemical Dependency	
Mental Health Outpatient	$15 copay per visit
Mental Health Inpatient	No charge
Chemical Dependency Outpatient	$15 copay per visit
Chemical Dependency Inpatient	No charge
Prescription Drugs	
Pharmacy/Retail: Generic(3)	$10 copay per prescription
Pharmacy/Retail: Brand(3)	$20 copay per prescription
Pharmacy/Retail: Day Supply	30-consecutive day supply
Mail Order - Generic(4)	$20 copay per prescription
Mail Order - Brand(4)	$40 copay per prescription
Mail Order - Day Supply	90-consecutive day supply
Other	
Skilled Nursing Facility (SNF)	No charge, limited to 60 days per benefit period
Infertility Services	$15 copay per visit
Hospice Care	No charge
Home Health Care	No charge
Durable Medical Equipment (DME)	No charge
Chiropractic Care	$15 copay per visit, limited to 20 visits per calendar year. Must use American Specialty Health Network.

Notes

(1) One well-woman office visit or office visit for physical exam per calendar year. Preventive screenings covered at no charge include all services mandated by the Patient Protection and Affordable Care Act.
(2) At birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months.
(3) Up to a 30-consecutive-day supply or an amount determined by the Health Plan formulary.
(4) Applies to refills for most maintenance drugs. The mail-order program does not apply to certain drugs and mailing is limited to addresses inside the Hawaii Service Area.

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to your Evidence of Coverage.

Kaiser Foundation Health Plan, Inc.
A NONPROFIT HEALTH PLAN - HAWAII REGION

2013 Summary of Important Changes for Contract Renewals for

Citigroup, #996

This summary does not apply to Added Choice out-of-network coverage, QUEST, Kaiser Permanente for Individuals and Families, federal, state, or Medicare members. Changes for Senior Advantage and Medicare Cost appear separately.

This summary does not fully describe your coverage. For details on your coverage, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders if any (collectively known as "Service Agreement"). The Service Agreement is the legally binding document between Health Plan and its members. In the event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control.

Your employer may have purchased benefits (referred to as "riders") that override some of these changes. However, riders are not available for some of the changes described below.

Under the Patient Protection and Affordable Care Act (PPACA), your coverage may be considered a "grandfathered plan." Some of the benefit changes below may not be applicable to a grandfathered plan.

BENEFIT AND CONTRACT CHANGES:

These changes become effective on your employer's contract renewal date, unless specified otherwise below.

1. **Preventive care services.** When required, the preventive care services benefit will expand in accordance with the Patient Protection and Affordable Care Act. These additional preventive care services are covered at no charge. (*effective 8/1/2012*)

BENEFIT AND CONTRACT CLARIFICATIONS:

These clarifications are effective immediately, unless otherwise specified below.

1. **Premium rebates.** Clarify that if Kaiser Permanente rebates premiums to an employer, then the employer must use the rebate for the benefit of its members.

2. **Gender reassignment exclusion.** Clarify that services, procedures, treatments and supplies related to gender reassignment surgery are excluded. Also clarify that this exclusion does not apply to treatment for complications resulting from gender reassignment services provided by a Kaiser Permanente physician and in a Kaiser Permanente facility.

3. **Durable medical equipment exclusion.** Clarify that durable medical equipment is excluded, except that diabetes and home phototherapy equipment is provided in accord with section W of the applicable benefit schedule.

4. **Third party lien rights.** Clarify that equitable claims for third party liability lien rights under Section 502(a)(3) of the Employee Retirement Income Security Act (ERISA) are not subject to mandatory arbitration.

5. **Compliance with Laws.** Clarify that employers will provide summaries of benefits and coverage (SBCs) to its participants as required by the Patient Protection and Affordable Care Act (PPACA) and that Kaiser Permanente will provide SBCs to members upon request.

6. **HIPAA Certificates of Creditable Coverage.** Clarify that employers must provide Kaiser Permanente timely enrollment information in order for Kaiser to complete and mail Certificates of Creditable Coverage as required by the Health Information Portability and Accountability Act (HIPAA).

7. **Observation.** Clarify that observation services are covered under the outpatient section.

8. **Radiation therapy.** Clarify that radiation therapy includes services such as radium therapy and radioactive isotope therapy.

9. **Formulary criteria.** Clarify that drugs and supplies must be on the Health Plan formulary and used in accordance with formulary guidelines or restrictions.

10. **Tobacco cessation drugs and products.** Clarify that tobacco cessation drugs and products must be prescribed by a licensed prescriber.

11. **Mail order program for prescribed drugs.** Clarify that the mail order program for prescribed drugs applies to contraceptive drugs, diabetes supplies, and tobacco cessation drugs and products.

12. **Self-administered drugs exclusion.** Clarify that self-administered drugs are excluded, except when required by state or federal law.

13. **Immunizations.** Clarify that prescribed immunizations include Influenza and Pneumococcal immunizations.

14. **Hospice care.** Clarify that while receiving hospice care, visits by a Kaiser Permanente physician are covered upon payment of $20.00 per visit.

15. **Urgent care services.** Clarify that urgent care services received within the service area from Kaiser Permanente physicians or at Kaiser Permanente-designated facilities also include after hours care.

16. **Diabetes supplies.** Clarify within the diabetes equipment section that diabetes supplies are covered under the prescribed drugs section.

Kaiser Permanente Group Plan
2013 Benefits summary

This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, benefit schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legally binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control. Senior Advantage members must refer to their Kaiser Permanente Senior Advantage Evidence of Coverage for a description of their benefits. Medicare Cost members must refer to their Kaiser Permanente Medicare Cost Evidence of Coverage for a description of their benefits.

You are covered for medically necessary services within the Hawaii service area at Kaiser Permanente facilities, and which are provided or arranged by a Kaiser Permanente physician. All care and services need to be coordinated by a Kaiser Permanente physician.

Unless explicitly described in a particular benefit section (e.g. physical therapy is explicitly described under the hospice benefit section), each medical service or item is covered in accord with its relevant benefit section. For example, drugs or laboratory services related to in vitro fertilization are not covered under the in vitro fertilization benefit. Drugs related to in vitro fertilization are covered under the prescribed drugs benefit section. Laboratory services related to in vitro fertilization are covered under the laboratory services benefit section.

Your employer may have purchased benefits (referred to as "riders") that override some of the benefits listed below. Riders, if any, are described after the Exclusions and Limitations section.

Section	Benefits	You pay
Outpatient Services	**Primary care and specialty care office visits** (office visits are limited to one or more of the following services: exam, history, medical decision making)	$15 per visit
	Choice of primary care providers and access to specialty care: • Member may choose any primary care physician available to accept Member. • Parents may choose a pediatrician as the primary care physician for their child. • Members do not need a referral or prior authorization for certain specialty care, such as Obstetrical or Gynecological care. • The physician may have to get prior authorization for certain services.	
	Outpatient surgery and procedures	$15 per visit
	Eye examinations for eyeglasses *	$15 per visit
	Ear examinations to determine the need for hearing correction	$15 per visit
	Routine immunizations	No charge
	Unexpected mass immunizations	50% of applicable charges
	Short-term physical, occupational and speech therapy ** (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply)	$15 per visit
	Dialysis	
	• Kaiser Permanente physician and facility services for dialysis	10% of applicable charges
	• Equipment, training and medical supplies for home dialysis	No charge
	Materials for dressings and casts	No charge†

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

▼ Members must pay their office visit copay for the office visit.

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You pay
Hospital inpatient care (for acute care registered bed patients)	**Hospital inpatient care** includes services such as: • Room and board • General nursing care and special duty nursing • Physicians' services • Surgical procedures • Respiratory therapy and radiation therapy • Anesthesia • Medical supplies • Use of operating and recovery rooms • Intensive care room	No charge
	Short-term physical, occupational and speech therapy ** (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply)	Included in the above hospital inpatient care copay
	Materials for dressings and casts	Included in the above hospital inpatient care copay
Laboratory, imaging, and testing services	**Inpatient laboratory services, imaging services, and testing services**	Included in hospital inpatient care copay
	Outpatient laboratory services, imaging services, and testing services	$15 copay per department per day
Transplants	**Transplants**, including kidney, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel, and small bowel-liver transplants *	See applicable benefit sections (e.g. - office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.)
Preventive screening services	**Preventive care services** (which protect against disease, promote health, and/or detect disease in its earliest stages before noticeable symptoms develop) • FDA approved contraceptive drugs and devices** that are available on the Health Plan formulary, as required by the federal Patient Protection and Affordable Care Act (PPACA). Coverage of all other FDA approved contraceptive drugs and devices are described in the Obstetrical care section. • Female sterilizations** • Rental or purchase of breast feeding pump, including any equipment that is required for pump functionality *A list of preventive care services provided at no charge is available through the Customer Service Center. This list is subject to change at any time. If you receive any other covered services during a preventive care visit, you will pay the applicable charges for those services.*	No charge; (non-preventive care services according to member's regular plan benefits)
	Preventive care office visits for: • Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months and 18 months) • One preventive care office visit per calendar year for members 2 years of age and over • One gynecological office visit per calendar year for female members	

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

▼ Members must pay their office visit copay for the office visit.

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You pay
Prescribed drugs	**Prescribed drugs that require skilled administration by medical personnel** (e.g. cannot be self-administered) which meet all of the following: • Prescribed by a Kaiser Permanente licensed prescriber, • On the Health Plan formulary and used in accordance with formulary criteria, guidelines or restrictions, and • Prescription is required by law	No charge ▼†
	Diabetes supplies **	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)
	Tobacco cessation drugs and products **	No charge
	Exclusions: • Self-administered drugs (such as drugs taken orally) • Drugs that are necessary or associated with services that are excluded or not covered Your group may have purchased drug coverage for self-administered drugs under a separate rider. If so, it will be listed on the attached pages.	

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

▼ Members must pay their office visit copay for the office visit.

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You pay
Obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services	**Routine obstetrical (maternity) care** • Prenatal visits at the routine scheduled intervals, uncomplicated delivery/hospital stay, and routine post-partum visit *Note: If member is discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), the member's Kaiser Permanente physician may order a follow-up visit for the member and newborn to take place within 48 hours after discharge.*	No charge after confirmation of pregnancy (non-routine obstetrical care according to member's regular plan benefits)
	Inpatient stay and inpatient care for newborn during or after mother's hospital stay (assuming newborn is timely enrolled on Kaiser Permanente subscriber's plan)	Hospital inpatient care benefits apply (see hospital inpatient care section)
	Family planning office visits	$15 per visit
	Involuntary infertility office visits	$15 per visit
	In vitro fertilization * • Limited to one-time only benefit at Kaiser Permanente • Limited to female members using spouse's sperm	20% of applicable charges
	Artificial insemination *	$15 per visit
Home health care and hospice care	**Home health care**, nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	No charge (office visit copay applies for physician house calls)
	Hospice care. Supportive and palliative care for a terminally ill member, as directed by a Kaiser Permanente physician. Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. The member must be certified by a Kaiser Permanente physician as terminally ill at the beginning of each period. (Hospice benefits apply in lieu of any other plan benefits for treatment of terminal illness.) Hospice includes services such as: • Nursing care (excluding private duty nursing) • Medical social services • Home health aide services • Medical supplies • Physician services • Counseling and coordination of bereavement services • Services of volunteers • Physical therapy, occupational therapy, or speech language pathology	No charge
Skilled nursing care	Up to **60 days of prescribed skilled nursing care services in an approved facility** (such as a hospital or skilled nursing facility) **per benefit period**. Covered services include nursing care, room and board, medical social services, medical supplies, and durable medical equipment ordinarily provided by a skilled nursing facility. In addition to Health Plan criteria, Medicare guidelines are used to determine when skilled nursing services are covered, except that a prior three-day stay in an acute care hospital is not required. **Exclusions:** Personal comfort items, such as telephone, television and take-home medical supplies.	No charge

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

▼ Members must pay their office visit copay for the office visit.

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You pay
Emergency services ▲ (covered for initial emergency treatment only)	At a facility within the Hawaii service area for covered emergency services	$50 per visit
	At a facility outside the Hawaii service area for covered emergency services	$50 per visit
	Note: Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility.	
	▲ *Emergency Services are those medically necessary services available through the emergency department to medically screen, examine and Stabilize the patient for Emergency Medical Conditions. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity that meet the prudent layperson standard and the absence of immediate medical attention will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or place the health of the individual in serious jeopardy.* ***Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.***	
Out-of-area urgent care services (while temporarily outside the Hawaii service area)	At a non-Kaiser Permanente facility for covered urgent care services (Coverage for initial urgent care treatment only)❖	20% of applicable charges
	❖ *"Urgent Care Services" means medically necessary services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.* ***Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.***	
Ambulance services	Ambulance Services are those services in which: • Use of any other means of transport, regardless of availability of such other means, would result in death or serious impairment of the member's health, and • Is for the purpose of transporting the member to receive medically necessary acute care. In addition, air ambulance must be for the purpose of transporting the Member to the nearest medical facility designated by Health Plan for receipt of medically necessary acute care, and the member's condition must require the services of an air ambulance for safe transport.	No charge
Blood	Regardless of replacement, units and processing of units of **whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin**	No charge †
	Collection, processing, and storage of autologous blood when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used	No charge †
Mental health services	Outpatient office visits	$15 per visit
	Hospital inpatient care	No charge
	Specialized facility services Services in a specialized mental health treatment unit or facility approved by Kaiser Permanente Medical Group	
	• Day treatment or partial hospitalization services	$15 per visit
	• Non-hospital residential services	No charge
Chemical dependency services	Outpatient office visits	$15 per visit
	Hospital inpatient care	No charge
	Specialized facility services Services in a specialized alcohol or chemical dependence treatment unit or facility approved by Kaiser Permanente Medical Group	
	• Day treatment or partial hospitalization services	$15 per visit
	• Non-hospital residential services	No charge

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

▼ Members must pay their office visit copay for the office visit.

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You pay
Internal prosthetics, devices, and aids **	**Implanted internal prosthetics** (such as pacemakers and hip joints), **and internally implanted devices and aids** (such as surgical mesh, stents, bone cement, implanted nuts, bolts, screws, and rods) which are prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan	No charge †
	Fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss	No charge †

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

▼ Members must pay their office visit copay for the office visit.

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You pay
Diabetes equipment and home phototherapy equipment	**Diabetes equipment** (limited to glucose meters and external insulin pumps, and the supplies necessary to operate them) which are prescribed by a Kaiser Permanente 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	50% of applicable charges
	Home phototherapy equipment for newborns which are prescribed by a Kaiser Permanente 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	No Charge
	Diabetes equipment and home phototherapy equipment is that equipment and supplies necessary to operate the equipment which: • Is intended for repeated use, • Is primarily and customarily used to serve a medical purpose, • Is appropriate for use in the home, • Is generally not useful to a person in the absence of illness or injury, • Was in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, • 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 diabetes equipment is prescribed, and • Is on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions.	
	Exclusions: • Comfort and convenience equipment, and devices not medical in nature. • Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages. • Repair, adjustment or replacement due to misuse or loss. • Experimental or research equipment.	
	Limitations: • If rented or loaned from Health Plan, the Member must return any diabetes equipment items 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 a Physician or used by the Member. • Coverage is limited to the standard item of diabetes equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.	
Dependent coverage	Dependent (biological, step or adopted) children of the Subscriber (or the Subscriber's spouse) are eligible up to the child's 26th birthday. Other dependents may include: • The Subscriber's (or Subscriber's spouse's) dependent (biological, step or adopted) children (over age 26) who are incapable of self-sustaining employment because of a 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 Subscriber's Spouse) (proof of incapacity and dependency may be required). • A person who is 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.	

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.

▼ Members must pay their office visit copay for the office visit.

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You pay
Supplemental charges maximum	**Your out-of-pocket expenses for covered Basic Health Services are capped each year by a supplemental charges maximum.**	$2,000 per member, $6,000 per family unit (3 or more members), for calendar year

YOU MUST RETAIN YOUR RECEIPTS for these supplemental charges and when that maximum amount has been **PAID**, present these receipts to our Business Office at Moanalua Medical Center, Honolulu, Waipio, or Wailuku Clinics, or to the cashier at other clinics. After verification that the supplemental charges maximum has been **PAID, you will be given a card** which indicates that no additional supplemental charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to **show this card** at your visits to ensure no additional supplemental charges are billed or collected for the remainder of the calendar year in which the medical services were received. **All payments are credited toward the calendar year in which the medical services were received.**

You will be provided an updated status about which of your payments may be applied to the supplemental charges maximum. Please allow a minimum of 10 working days to verify that your supplemental charge maximum has been met.

Note: Once you have met the supplemental charges maximum, please submit your proof of payment as soon as reasonably possible. All receipts must be submitted no later than February 28 of the year following the one in which the medical services were received.

Supplemental charges for the following covered Basic Health Services can be applied toward the supplemental charges maximum: ambulance service, artificial insemination, chemical dependency services (including residential services), dialysis, drugs requiring skilled administration, emergency service, family planning office visits, health evaluation office visits for adults, home health, imaging (including X-rays), immunizations (excluding travel immunizations), in vitro fertilization procedure (excluding drugs), infertility office visits, inpatient room (semi-private), interrupted pregnancy/abortion, laboratory, mental health services, obstetrical (maternity) care, covered office visits for services listed in this Basic Health Services section, outpatient surgery and procedures, radiation and respiratory therapy, reconstructive surgery, short-term physical therapy, short-term speech therapy, short-term occupational therapy, testing services, transplants (the procedure), and urgent care.

These are not Basic Health Services and charges for these services/items are ***not*** applicable towards the supplemental charges maximum: all services for which coverage has been exhausted, all excluded or non-covered benefits, all other services not specifically listed above as a Basic Health Service, allergy test materials, blood or blood processing, braces, complementary alternative medicine (chiropractic, acupuncture, or massage therapy), contraceptive drugs and devices, dental services, diabetes supplies and equipment, dressings and casts, durable medical equipment, external prosthetics, handling fee or taxes, health education services, classes or support groups, hospice, internal prosthetics, internal devices and aids, medical foods, medical social services, office visits for services which are not Basic Health Services, orthopedic devices, radioactive materials, self administered/outpatient prescription drugs, skilled nursing care, take-home supplies, and travel immunizations.

† When provided in an outpatient office visit, copay is as indicated. When service or items are received in any other setting (e.g., hospital inpatient, skilled nursing facility, or outpatient surgery or procedure in an ASC), the copay is in accord with the relevant benefit section.
▼ Members must pay their office visit copay for the office visit.
* See **Coverage Exclusions**
** See **Coverage Limitations**

Coverage exclusions for in-network Services

When a Service is excluded or non-covered, all Services that are necessary or related to the excluded or non-covered Service are also excluded. "Service" means any treatment, diagnosis, care, procedure, test, drug, injectable, facility, equipment, item, device, or supply. The following Services are excluded:

- **Acupuncture.** (This exclusion may not apply if you have the applicable Complementary Alternative Medicine Rider.)
- **Alternative medical Services** not accepted by standard allopathic medical practices such as: hypnotherapy, behavior testing, sleep therapy, biofeedback, massage therapy, naturopathy, rest cure and aroma therapy. (The massage therapy portion of this exclusion may not apply if you have the applicable Complementary Alternative Medicine Rider.)
- **Artificial aids, corrective aids, and corrective appliances** such as external prosthetics, braces, orthopedic aids, orthotics, hearing aids, corrective lenses and eyeglasses. (The external prosthetic devices and braces portion of this exclusion may not apply if you have an External Prosthetic Devices and Braces Rider. The hearing aids portion of this exclusion may not apply if you have a Hearing Aid Rider. The eyeglasses and contact lens portion of this exclusion may not apply if you have an Optical Rider).
- **All blood, blood products, blood derivatives, and blood components** whether of human or manufactured origin and regardless of the means of administration, except as stated under the "Blood" section. Donor directed units are not covered.
- **Cardiac rehabilitation.**
- **Chiropractic Services.** (This exclusion may not apply if you have the applicable Complementary Alternative Medicine Rider.)
- Services for **confined members** (confined in criminal institutions, or quarantined).
- **Contraceptive foams and creams, condoms** or other non-prescription substances used individually or in conjunction with any other prescribed drug or device.
- **Cosmetic Services**, such as plastic surgery to change or maintain physical appearance, which is not likely to result in significant improvement in physical function, including treatment for complications resulting from cosmetic services. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery, incident to a covered mastectomy, or cosmetic service provided by a Physician in a Health Plan facility are covered.
- **Custodial Services or Services in an intermediate level care facility.**
- **Dental care Services** such as dental x-rays, dental implants, dental appliances, or orthodontia and Services relating to temporomandibular joint dysfunction (TMJ) or Craniomandibular Pain Syndrome. (Part of this exclusion may not apply if you have a Dental Rider.)
- **Durable medical equipment**, such as crutches, canes, oxygen-dispensing equipment, hospital beds and wheelchairs used in the member's home (including an institution used as his or her home), except diabetes blood glucose monitors and external insulin pumps. (This exclusion does not apply if you have a Durable Medical Equipment Rider.)
- **Employer or government responsibility**: Services that an employer is required by law to provide or that are covered by Worker's Compensation or employer liability law; Services for any military service-connected illness, injury or condition when such Services are reasonably available to the member at a Veterans Affairs facility; Services required by law to be provided only by, or received only from, a government agency.
- **Experimental or investigational Services.**
- **Eye examinations** for contact lenses (Eye exams for contact lens may be partially covered if you have an Optical Rider.) and vision therapy, including orthoptics, visual training and **eye exercises**.
- **Eye surgery** solely for the purpose of correcting refractive defects of the eye, such as Radial keratotomy (RK), and Photo-refractive keratectomy (PRK).
- **Routine foot care**, unless medically necessary.
- **Health education:** specialized health promotion classes and support groups (such as the bariatric surgery program).
- **Homemaker Services.**
- The following costs and Services for **infertility services, in vitro fertilization or artificial insemination:**
  - The cost of equipment and of collection, storage and processing of sperm.

- In vitro fertilization using either donor sperm or donor eggs.
- In vitro fertilization that does not meet state law requirements.
- Services related to conception by artificial means other than artificial insemination or in vitro fertilization, such as ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), including prescription drugs related to such Services and donor sperm and donor eggs used for such Services.
- Services to reverse voluntary, surgically-induced infertility.

- **Non FDA-approved drugs and devices.**
- **Certain exams and Services**. Certain Services and related reports/paperwork, in connection with third party requests, such as those for: employment, participation in employee programs, sports, camp, insurance, disability, licensing, or on court-order or for parole or probation. Physical examinations that are authorized and deemed medically necessary by a Kaiser Permanente physician and are coincidentally needed by a third party are covered according to the member's benefits.
- **Radial keratotomy (RK), Photo-refractive keratectomy (PRK),** and similar procedures.
- Long term **physical therapy, occupational therapy, speech therapy;** maintenance therapies; physical, occupational, and speech therapy deficits due to developmental delay; therapies not expected to result in significant, measurable improvement in physical function with short-term therapy.
- **Services not generally and customarily available in the Hawaii service area.**
- **Services and supplies not medically necessary.** A service or item is medically necessary (in accord with medically necessary state law definitions and criteria) only if, 1) recommended by the treating Kaiser Permanente physician or treating Kaiser Permanente licensed health care practitioner, 2) is approved by Kaiser Permanente's medical director or designee, and 3) is for the purpose of treating a medical condition, is the most appropriate delivery or level of service (considering potential benefits and harms to the patient), and known to be effective in improving health outcomes. Effectiveness is determined first by scientific evidence, then by professional standards of care, then by expert opinion. Coverage is limited to the services which are cost effective and adequately meet the medical needs of the member.
- All Services, drugs, injections, equipment, supplies and prosthetics related to treatment of **sexual dysfunction**, except evaluations and health care practitioner's services for treatment of sexual dysfunction.
- All Services, drugs, prosthetics, devices or surgery related to **gender re-assignment**.
- **Take home supplies** for home use, such as bandages, gauze, tape, antiseptics, ace type bandages, drug and ostomy supplies, catheters and tubing.
- The following costs and Services for **transplants**:
  - Non-human and artificial organs and their transplantation.
  - Bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tissue tumors, except for germ cell tumors and neuroblastoma in children.
- Services for injuries or illness caused or alleged to be caused by **third parties or in motor vehicle accidents**.
- **Transportation** (other than covered ambulance services), **lodging, and living expenses**.
- **Travel immunizations.**
- **Services for which coverage has been exhausted, Services not listed as covered, or excluded Services.**

Coverage limitations for in-network Services

Benefits and Services are subject to the following limitations:

- In-network benefits and services must be performed, prescribed, or directed by a Kaiser Permanente Physician.
- Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.
- Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when physicians believe no professionally acceptable alternative to treatment exists. Coverage will cease at the point the member stops following the recommended treatment.
- Members are covered for **contraceptive drugs and devices** only when the prescription drugs meet all of the following criteria: 1) prescribed by a licensed Prescriber, 2) the drug is one for which a prescription is required by law, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc.

- **Durable medical equipment** (if you have a Durable Medical Equipment Rider), and **external prosthetics** and braces (if you have an External Prosthetic Devices and Braces Rider) are subject to Medicare coverage guidelines and limitations.
- When covered under the preventive care services section, the following types of **female sterilizations** and related items and services are provided: 1) sterilization surgery for women: Trans-abdominal Surgical Sterilization/Surgical Implant; 2) sterilization implant for women: Trans-cervical Surgical Sterilization Implant; 3) pre and post operative visits associated with female sterilization procedures; and 4) Hysterosalpingogram test following sterilization implant procedure.
- Specialty **imaging services** are services such as CT, interventional radiology, MRI, nuclear medicine, and ultrasound. General radiology includes services such as x-rays and diagnostic mammography.
- **Internal prosthetics, devices, and aids** (such as pacemakers, hip joints, surgical mesh, stents, bone cement, bolts, screws, and rods) are those which meet all of the following: 1) are required to replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ, 2) are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA), 3) were in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, and 4) are not excluded from coverage from Medicare, and if covered by Medicare, meet the coverage definitions, criteria and guidelines established by Medicare at the time the device is prescribed. The following are excluded from coverage: 1) all implanted internal prosthetics and devices and internally implanted aids related to an excluded or non covered service/benefit, and 2) Prosthetics, devices, and aids related to sexual dysfunction. Coverage is limited to the standard prosthetic model that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.
- **Diabetes equipment** and supplies necessary to operate them are subject to Medicare coverage guidelines and limitations, must be preauthorized in writing by Kaiser Permanente, and obtained from a Health Plan designated vendor.
- Up to a 30-consecutive-day supply of **diabetes supplies** is provided (as described under the **prescribed drugs** section) if all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate.
- **Home phototherapy and diabetes equipment** which are prescribed by a Kaiser Permanente 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 is that equipment and supplies necessary to operate the equipment which: 1) is intended for repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) is appropriate for use in the home, 4) is generally not useful to a person in the absence of illness or injury, 5) was in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, 6) 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 diabetes equipment is prescribed, and 7) is on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions. The following are excluded items or services: 1) comfort and convenience equipment, and devices not medical in nature, 2) disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages, 3) repair, adjustment or replacement due to misuse or loss, and 4) experimental or research equipment. The following limitations apply to diabetes and home phototherapy equipment: 1) if rented or loaned from Health Plan, the Member must return any diabetes or home phototherapy equipment items 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 a Physician or used by the Member, and 2) coverage is limited to the standard item of diabetes or home phototherapy equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.
- Specialty **laboratory services** include tissue samples, cell studies, chromosome studies, and testing for genetic diseases.
- Short-term **physical, occupational and speech therapy Services** means medical services provided for those conditions which meet all of the following criteria: a) the therapy is ordered by a Physician under an individual treatment plan; b) in the judgment of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy; c) the therapy is provided by or under the supervision of a Physician-designated licensed physical, speech, or occupational therapist, as appropriate; and d) as determined by a Physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury. Neurological and/or musculoskeletal function is sufficient when one of the following **first** occurs: 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. **Occupational therapy** is limited to hand rehabilitation services, and medical services to achieve improved self care and other customary activities of daily living. **Speech-language pathology** is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin. 1
- Up to a 30-consecutive-day supply of **tobacco cessation drugs and products** is provided when all of the following criteria are met: 1) available on the Health Plan formulary.s Tobacco Cessation list of approved drugs and products, including

over-the-counter drugs and products, and in accordance with formulary criteria, guidelines, or restrictions, 2) 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 3) Member meets Health Plan-approved program-defined requirements for smoking cessation classes or counseling (tobacco cessation classes and counseling sessions are provided at no charge).

- **Tuberculin skin test** is limited to one per calendar year, unless medically necessary.
- **Transplant** services for transplant donors. Health Plan will pay for medical services for living organ and tissue donors and prospective donors if the medical services meet all of the requirements below. Health Plan pays for these medical services as a courtesy to donors and prospective donors, and this document does not give donors or prospective donors any of the rights of Kaiser Permanente Members.
  - Regardless whether the donor is a Kaiser Permanente member or not, the terms, conditions, and Supplemental Charges of the transplant-recipient Kaiser Permanente member will apply. Supplemental charges for medical services provided to transplant donors are the responsibility of the transplant-recipient Kaiser Permanente member to pay, and count toward the transplant-recipient Kaiser Permanente member's limit on supplemental charges.
  - The medical services required are directly related to a covered transplant for a Kaiser Permanente member and required for a) screening of potential donors, b) harvesting the organ or tissue, or c) treatment of complications resulting from the donation.
  - For medical services to treat complications, the donor receives the medical services from Kaiser Permanente practitioners inside a Health Plan Region or Group Health service area.
  - Health Plan will pay for emergency services directly related to the covered transplant that a donor receives from non Kaiser Permanente practitioners to treat complications.
  - The medical services are provided not later than three months after the donation.
  - The medical services are provided while the transplant-recipient is still a Kaiser Permanente member, except that this limitation will not apply if the Kaiser Permanente member's membership terminates because he or she dies.
  - Health Plan will not pay for travel or lodging for donors or prospective donors.
  - Health Plan will not pay for medical services if the donor or prospective donor is not a Kaiser Permanente member and is a member under another health insurance plan, or has access to other sources of payment.
  - The above policy does not apply to blood donors.

Third party liability, motor vehicle accidents, and surrogacy health services

Kaiser Permanente has the right to recover the cost of care for a member's injury or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the member by an insurance company, individual or other third party. Kaiser Permanente has the right to recover the cost of care for Surrogacy Health Services. Surrogacy Health Services are Services the Member receives related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement. The Member must reimburse Kaiser Permanente for the costs of Surrogacy Health Services, out of the compensation the Member or the Member's payee are entitled to receive under the Surrogacy Arrangement.

	Benefits	You pay
Durable medical equipment rider - $0	**Durable medical equipment**, including oxygen dispensing equipment (and oxygen), used during a covered stay in a Hospital or Skilled Nursing Facility	No Charge
	Medically necessary and appropriate **durable medical equipment for use in the home**, 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	No charge
	Oxygen for use in conjunction with prescribed durable medical equipment	No charge
	Repair, replacement and adjustment of durable medical equipment, other than those due to misuse or loss	No charge

Durable medical equipment is that equipment and related supplies which meet all of 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,
- Is generally not useful to a person in the absence of illness or injury,
- Was in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, and
- 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.

Exclusions:

- All durable medical equipment related to an excluded or non-covered service/benefit
- Supplies, whether or not related to durable medical equipment
- Comfort and convenience equipment, disposable supplies, and devices not medical in nature such as sauna baths and elevators
- Exercise and hygiene equipment
- Electronic monitors of the function of the heart or lungs
- Diabetes equipment.
- Devices to perform medical tests on blood or other body substances or excretions
- Dental appliances or devices
- Repair, replacement or adjustment due to misuse or loss
- Experimental or research equipment
- Durable medical equipment related to sexual dysfunction
- Modifications to a home or car

Limitations:

- If rented or loaned from Health Plan, the Member must return any durable medical equipment items 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 a Physician or used by the Member.
- 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.

	Benefits	You pay
External prosthetic devices and braces rider - $0	**External prosthetic devices and braces**, when prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan	No charge
	Fitting and adjustment of these devices, including repairs and replacements other than those due to misuse or loss	No charge
	A prosthetic device following mastectomy, if all or part of a breast is surgically removed for medically necessary reasons. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.	No charge

Definitions:

External Prosthetic Devices are those which meet 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 Service Agreement 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.

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.

Exclusions:

- All external prosthetic devices and braces related to an excluded or non-covered service/benefit
- Supplies, whether or not related to external prosthetic devices or braces
- Prosthetic devices related to sexual dysfunction
- 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 prosthetics for comfort and/or convenience, or which are not medical in nature
- Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages

Limitations:

- 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.

	Benefits	You pay
Hearing Aids rider - $500 allowance	Up to $500 allowance per calendar year for up to 2 hearing aid(s) every 36 months, when prescribed by a KP physician or KP audiologist, and obtained from sources designated by Health Plan **Exclusions:** • All other hearing aid related costs, including but not limited to: consultation, fitting, rechecks and adjustments for the hearing aid(s). • All other costs greater than the $500 allowance given once every 36 months.	$500 less than regular cost

	Benefits	You pay
National Accounts 2-tiered drug rider $10/$20	**For each prescription, when the quantity does not exceed:** • a 30-consecutive-day supply of a prescribed drug, or • an amount as determined by the formulary.	$10 per generic drug prescription, $20 per brand-name drug prescription
	Self-administered drugs are covered only when all of the following criteria are met: • prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate, • on the Kaiser Permanente Hawaii Drug Formulary. Senior Advantage members with Medicare Part D are entitled to drugs on the Kaiser Permanente Hawaii Drug Formulary and Kaiser Permanente Hawaii Medicare Drug Formulary. Drugs must be used in accordance with formulary criteria, guidelines, or restrictions, • the drug is one for which a prescription is required by law, • obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc., or pharmacies we designate, and • drug does not require administration by nor observation by medical personnel..	
	Insulin	$10 per generic drug prescription
	Contraceptive drugs and devices are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section	

Exclusions:

- Drugs for which a prescription is not required by law (e.g. over-the-counter drugs) including condoms, contraceptive foams and creams or other non-prescription substances used individually or in conjunction with any other prescribed drug or device.
- Drugs and their associated dosage strengths and forms in the same therapeutic category as a non-prescription drug that have the same indication as the non-prescription drug.
- Drugs obtained from a non-Kaiser Permanente pharmacy.
- Non-prescription vitamins.
- Drugs when used primarily for cosmetic purposes.
- Medical supplies such as dressings and antiseptics.
- Reusable devices such as blood glucose monitors and lancet cartridges.
- Diabetes supplies such as blood glucose test strips, lancets, syringes and needles.
- Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate.
- Brand-name drugs requested by a Member when there is a generic equivalent.
- Prescribed drugs that are necessary for or associated with excluded or non-covered services, except for Senior Advantage Members with Medicare Part D.
- Drugs related to sexual dysfunction.
- Drugs to shorten the duration of the common cold.
- Drugs related to enhancing athletic performance (such as weight training and body building).
- Any packaging other than the dispensing pharmacy's standard packaging.
- Immunizations, including travel immunizations.
- Contraceptive drugs and devices (to prevent unwanted pregnancies).
- Abortion drugs (such as RU-486).
- Replacement of lost, stolen or damaged drugs.

Questions and answers about the drug rider

1. ***How does the drug rider work?***
   When you visit a Kaiser Permanente physician, a licensed prescriber or a prescriber we designate, and they prescribe a drug for which a prescription is legally required, you can take it to any Kaiser Permanente pharmacy or pharmacy we designate.

   - In most cases you will be charged only $10 for a generic drug prescription and $20 for a brand-name drug prescription when it does not exceed a 30-consecutive-day supply of a prescribed drug (or an amount as determined by the formulary). Each refill of the same prescription will also be provided at the same charge. A generic drug that is available in the United States only from a single source manufacturer and that is not listed as generic in the then current commercially available drug database(s) to which Health Plan subscribes, is provided upon payment of $20 if the quantity prescribed does not exceed (i) a 30-consecutive-day supply, or (ii) an amount as determined by the formulary.
   - If you go to a non-Kaiser Permanente pharmacy, you will be responsible for 100% of charges.

2. ***Where are Kaiser Permanente pharmacies located?***
   Most Kaiser Permanente Clinics have a pharmacy on premises. Please consult the Member Handbook for the pharmacy nearest you and its hours of operation.

3. ***Can I get any drug prescribed by my Physician?***
   Our drug formulary is considered a closed formulary, which means that medications on the list are usually covered under the prescription drug rider. However drugs on our formulary may not be automatically covered under your prescription drug rider depending on which plan you've selected. Even though nonformulary drugs are generally not covered under your prescription drug rider, your Kaiser Permanente physician can sometimes request a nonformulary drug for you, specifically when formulary alternatives have failed or use of nonformulary drug is medically necessary, provided – the drug is not excluded under the prescription drug rider.

   Kaiser Permanente pharmacies may substitute a chemical or generic equivalent for a brand-name drug unless this is prohibited by your Kaiser Permanente physician. If you want a brand-name drug for which there is a generic equivalent, or if you request a non-formulary drug, you will be charged Member Rates for these selections, since they are not covered under your prescription drug rider. If your KP physician deems a higher priced drug to be medically necessary when a less expensive drug is available, you pay the usual drug copayment. If you request the higher priced drug and it has not been deemed medically necessary, you will be charged Member Rates.

4. ***Do I need to present any identification when I receive drugs?***
   Yes, always present your Kaiser Permanente membership ID card, which has your medical record number, to the pharmacist. If you do not have a medical record number, please call the Customer Service Center at 432-5955 on Oahu or 1-800-966-5955 on Neighbor Islands.

5. ***What if I need more than a month's supply of medication?***
   Your Kaiser Permanente membership contract entitles you to a maximum one-month's supply per prescription. However, as a convenience to you, our Kaiser Permanente Pharmacies will dispense up to a three-month's supply of certain prescriptions upon request (you will be responsible for three copayment amounts). Dispensing a three-month's supply is done in good faith, presuming you will remain a Kaiser Permanente member for the next three months. If you terminate your membership with Kaiser Permanente before the end of the three-month period, we will bill you the retail price for your remaining drugs. For example, if you end your membership after two months, we will bill you for the remaining one-month's supply. Refills are allowed when 75% of the current prescription supply is taken/administered according to prescriber's directions.

6. ***How do I receive prescriptions by mail?***
   Save time and money on refills! If you have prescription drug coverage, you can get a 90-day supply of qualified prescription drugs covered under your drug rider for the price of 60 by using our convenient mail order service*. And we pay the postage!

   You can order your refills at your convenience, 24/7, using one of the methods below.

   - For the quickest turnaround time, order online at kp.org.
   - Order via our automated prescription refill service by calling 432-7979 (Oahu) or 1-888-867-2118 (Neighbor Islands). You'll have the following options:
     - To check your order status, press 1.
     - To order refills, press 2. You will be asked to enter your medical record number and prescription number. Then you'll have the option of receiving your refills via mail order (by pressing 1) or picking up your refills at one of our locations (by pressing 2)
     - To listen to detailed instructions, press 3.
   - Order using our mail-order envelope, available at all Kaiser Permanente clinic locations.
   - Order via our Pharmacy Refill Center at (808) 432-5510 (Oahu), or toll free 1-866-250-1805 (Neighbor Islands), Monday to Friday, 8:30 a.m. to 5 p.m. TTY users may call 1-877-447-5990.

   So the next time you've used two-thirds of your existing supply of prescription medications, try using one of these convenient options.

   If you must pick up your prescriptions at a clinic pharmacy, refillable prescriptions are usually ready for pickup at the designated pharmacy in

one business day. Prescriptions requiring a physician's approval are usually ready in two business days. Call the pharmacy or Kaiser Permanente Hawaii's automated prescription refill line in advance to make sure that your prescription is ready. Orders not picked up within one week are returned to stock.

*We are not licensed to mail medications out of state. There are restrictions for delivery of certain medications and supplies, including but not limited to controlled medications, injections, medications affected by temperature, and medications excluded by Kaiser Permanente's Pharmacy & Therapeutic Committee.

This brochure is only a summary.

It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, benefit schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control.

	Benefits	You pay
Alternative medicine rider A - 20 visits / $15	**Chiropractic services** **Up to a maximum of 20 office visits per calendar year. This rider does not cover services which are performed or prescribed by a Kaiser Permanente physician or other Kaiser Permanente health care provider.** Services must be performed and received from Participating Chiropractors of **American Specialty Health Networks (ASHN)**. Covered Services include: • **Chiropractic services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders which are authorized by ASHN and performed by a Participating Chiropractor. • **Adjunctive therapy** as set forth in a treatment plan approved by ASHN, which may involve chiropractic modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies. • **Diagnostic tests** are limited to those required for further evaluation of the Member's condition and listed on the payor summary and fee schedule. Medically necessary x-rays, radiologic consultations, and clinical laboratory studies must be performed by either an appropriately certified Chiropractor or staff member or referred to a facility that has been credentialed to meet the criteria of ASHN. Diagnostic tests must be performed or ordered by a Participating Chiropractor and authorized by ASHN.	$15 copayment per office visit
	Chiropractic appliances when prescribed and provided by a Participating Chiropractor and authorized by ASHN.	Payable up to a maximum of $50 per calendar year

Exclusions:

- Any Chiropractic service or treatment not furnished by a Participating Chiropractor and not provided in the Participating Chiropractor's office.
- Examination and/or treatment by a Chiropractor of conditions other than Neuromusculo-skeletal Disorders.
- Services, lab tests, x-rays and other treatments not documented as medically necessary or as appropriate.
- Services, lab tests, x-rays and other treatments classified as experimental or investigational.
- Diagnostic scanning and advanced radiographic imaging, including Magnetic Resonance Imaging (MRI), CAT scans, and/or other types of diagnostic scanning or therapeutic radiology; thermography; bone scans, nuclear radiology, any diagnostic radiology other than plain film studies.
- Alternative medical services not accepted by standard allopathic medical practices including, but not limited to, acupuncture, hypnotherapy, behavior training, sleep therapy, weight programs, massage therapy, lomi lomi, educational programs, naturopathy, podiatry, rest cure, aroma therapy, osteopathy, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing.
- Vitamins, minerals, nutritional supplements, botanicals, ayurvedic supplements, homeopathic remedies or other similar-type products.
- Nutritional supplements which are Native American, South American, European, or of any other origin.
- Traditional Chinese herbal supplements.
- Nutritional supplements obtained by Members through a health food store, grocery store or by any other means.
- Prescriptive and non prescriptive drugs, injectables and medications.
- Transportation costs, such as ambulance charges.

Benefits	You pay

- Hospitalization, manipulation under anesthesia, anesthesia or other related services.
- Services or treatment for pre-employment physicals or vocational rehabilitation.
- Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances (except as covered above in this brochure) or durable medical equipment.
- Services provided by a chiropractor outside the State of Hawaii.
- All auxiliary aids and services, such as interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Services and/or treatment which are not documented as Medically Necessary services.
- Any services or treatment not authorized by ASHN, except for an initial examination.
- Any office visits beyond 20 per calendar year.

What you need to know about your alternative medicine benefits

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

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

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

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