KAISER PERMANENTE®

KP Hawaii 301
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2018 Features of your Kaiser Permanente Group Plan

This is only a summary and is to be used for marketing purposes only. 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". For additional information please also refer to your group detailed benefit summary, to *Our physicians and locations* directory for practitioner and provider availability and to your *Member handbook*

Section	Benefits	You Pay
Supplemental charges maximum**	Your copays and coinsurance for covered Basic Health Services are capped by a **supplemental charges maximum**	$2,500 / $7,500
Deductible	Deductible**	None
Outpatient services	**Office visits****	
	• For primary care	$20 per visit
	• With a Specialist	$20 per visit
	Outpatient surgery and procedures	
	• Provided in medical office during a primary care visit	$20 per visit
	• Provided in medical office with a Specialist	$20 per visit
	• Provided in an ambulatory surgery center (ASC) or hospital-based setting	10% of applicable charges
	• Routine pre- and post-surgical office visits in connection with a covered surgery	No charge
Outpatient laboratory, imaging, and testing services	**Laboratory services****	$10 copay per day except 20% of applicable charges for complex labs
	Imaging services**	
	• General radiology	$10 copay per day
	• Specialty imaging services	20% of applicable charges
	Testing services**	20% of applicable charges
Preventive care services	**Preventive care office visits for:** • Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, and 5 years) • Routine immunizations • One preventive care office visit per accumulation period for members 6 years of age and over • One gynecological office visit per accumulation period for female members	No charge
Prescribed Drugs	**Self-administered**	**Not included** (Applies towards the annual supplemental charges maximum per calendar year)
	Prescribed drugs that require skilled administration by medical personnel, such as injections and infusions (e.g. cannot be self-administered)**	
	• Provided in a medical office▼	20% of applicable charges
	• Provided during other settings, such as hospital stay, outpatient surgery, skilled nursing care	Applicable cost shares apply. See applicable benefit sections†

▼ Members must pay their office visit copay for the office visit.
† For example, office visits are subject to office visit copay, inpatient care are subject to inpatient care cost share, lab, imaging and testing are subject to lab, imaging and testing cost share, etc.
* See **Coverage Exclusions**
** See **Coverage Limitations**

Section	Benefits	You Pay
	Diabetes supplies**	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)
	Tobacco cessation drugs and products**	No charge
	Other drug therapy services	
	• Home IV/Infusion therapy**	No charge
	• Medically necessary growth hormone therapy	Applicable cost shares apply.
	• Prescribed inhalation therapy	See applicable benefit sections†
	Routine immunizations	No charge
Obstetrical Care	Routine prenatal visits	No charge
	Routine postpartum visit	No charge
	Delivery/hospital stay (uncomplicated)	10% of applicable charges
Hospital Inpatient care	Hospital inpatient care	10% of applicable charges
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 copays apply to physician visits)
	Hospice care**	No charge (office visit copays apply to physician visits)
Emergency services	**Emergency services**** within and outside the Hawaii service area *Note: The copayment for emergency services is waived if you are directly admitted as a hospital inpatient from the emergency department (the hospital copay will apply)*	$100 per visit / $100 per visit
Urgent care services	**Urgent care services****	
	• At a Kaiser Permanente (or Kaiser Permanente-designated) urgent care center within the Hawaii service area, for primary care services	$20 per visit
	• At a non-Kaiser Permanente facility outside the Hawaii service area	20% of applicable charges
Ambulance services	Ambulance services**	20% of applicable charges
Durable medical equipment**	**Diabetes equipment**	50% of applicable charges
	Home phototherapy equipment for newborns	No charge
	Breast feeding pump, including any equipment that is required for pump functionality	No charge
	All other **durable medical equipment**	20% of applicable charges
External prosthetic devices and braces**	**External prosthetic devices and braces**	20% of applicable charges

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

† For example, office visits are subject to office visit copay, inpatient care are subject to inpatient care cost share, lab, imaging and testing are subject to lab, imaging and testing cost share, etc.

* See **Coverage Exclusions**

** See **Coverage Limitations**

Section	Benefits	You Pay
Fit Rewards	per calendar year	$200 gym membership or $10 home fitness program

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* See **Coverage Exclusions**
** See **Coverage Limitations**

KP Hawaii 301
2018 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.

You are covered for Medically Necessary services at Kaiser Permanente facilities within the Hawaii service area, and which are provided, prescribed or directed by a Kaiser Permanente physician and consistent with reasonable medical management techniques specified under this plan 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 state law. All care and services need to be coordinated by a Kaiser Permanente physician except for emergency services, urgent care or services authorized by a written referral.

Riders, if any, are described after the Exclusions and Limitations sections.

If you receive covered services and items in one of these seven care settings, you only pay a single copay or coinsurance: hospital, observation, outpatient surgery and procedures in an ambulatory surgery center or outpatient hospital-based setting, skilled nursing facility, dialysis, radiation therapy and emergency room services. However, services and items received during an emergency room visit are included in the copay or coinsurance for emergency services, except complex imaging services (including interpretation of imaging) are covered under the complex imaging benefit.

For settings that are not mentioned above, each medical service or item is covered in accord with its relevant benefit section.

Section	Benefits	You pay
Supplemental charges maximum **	Your copays and coinsurance for covered Basic Health Services are capped by a **supplemental charges maximum**	$2,500 per member, $7,500 per family unit (3 or more members) per year
Deductible	Deductible **	None
Outpatient services	**Office visits ****	
	• For primary care	$20 per visit
	• With a Specialist	$20 per visit
	Outpatient surgery and procedures	
	• Provided in medical office during a primary care visit	$20 per visit
	• Provided in medical office with a Specialist	$20 per visit
	• Provided in an ambulatory surgery center (ASC) or hospital-based setting	10% of applicable charges
	• Routine pre- and post-surgical office visits in connection with a covered surgery	No charge
	Telehealth	Applicable cost shares apply. See applicable benefit sections†
	Allergy testing	$20 per visit
	Allergy treatment materials that are on Kaiser Permanente's formulary and require skilled administration by medical personnel	20% of applicable charges
	Chemotherapy, includes the treatment of infections or malignant diseases	
	• Office visits	$20 per visit
	• Chemotherapy infusions or injections that require skilled administration by medical personnel	20% of applicable charges

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***** See **Coverage Exclusions** Section
****** See **Coverage Limitations** Section

Section	Benefits	You pay
	• Self-administered oral chemotherapy *Note: In accordance with state law, oral chemotherapy will be administered at the same or lower cost share as intravenous chemotherapy.*	Self-administered/take home drug copay (if you have a drug rider) or 20% of applicable charges (if you do not have a drug rider)
	*** Physical, occupational and speech therapy **** Note: includes short-term therapy only (ie. Habilitative services are not covered)	$20 per visit
	Autism services**	Applicable cost shares apply. See applicable benefit sections†
	Dialysis • Kaiser Permanente physician and facility services for dialysis • Equipment, training and medical supplies for home dialysis	 20% of applicable charges No charge
	Materials for dressings and casts	Applicable cost shares apply. See applicable benefit sections†
Outpatient laboratory, imaging, and testing services	**Laboratory services ****	$10 per day for basic lab services and 20% of applicable charges for specialty lab services
	Imaging services ** • General radiology • Specialty imaging services	 $10 per day 20% of applicable charges
	Testing services **	20% of applicable charges
Outpatient radiation therapy	**Radiation therapy ****	20% of applicable charges
Observation	**Observation**	10% of applicable charges
Hospital inpatient care	**Hospital inpatient care ****	10% of applicable charges
	*** Physical, occupational and speech therapy **** Note: includes short-term therapy only (ie. Habilitative services are not covered)	Included in the above hospital inpatient care cost share
Transplants	*** Transplants ****	Applicable cost shares apply. See applicable benefit sections†

Preventive care services	**Preventive care services** (which protect against disease, promote health, and/or detect disease in its earliest stages before noticeable symptoms develop), including:
	• Screening services for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF), such as:
	  • Preventive counseling services
	  • Screening laboratory services
	  • Screening radiology services
	• 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 Prescribed drugs section.
	• Female sterilizations**
		No charge
		(non-preventive care services according to member's regular plan benefits)

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***** See **Coverage Exclusions** Section

****** See **Coverage Limitations** Section

Section	Benefits	You pay
	• Purchase of breast feeding pump, including any equipment that is required for pump functionality *A complete list of preventive care services provided at no charge is available through Member Services. 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.* **Preventive care office visits for:** • Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, and 5 years) • One preventive care office visit per year for members 6 years of age and over • One gynecological office visit per year for female members	
Prescribed drugs	**Prescribed drugs that require skilled administration by medical personnel**, such as injections and infusions (e.g. cannot be self-administered) **	
	• Provided in a medical office	20% of applicable charges ▼
	• Provided during other settings, such as hospital stay, outpatient surgery, skilled nursing care	Applicable cost shares apply. See applicable benefit sections†
	Prescribed **Self-administered drugs** (such as drugs taken orally)	If applicable see attached Drug summary, otherwise not covered
	**Diabetes supplies ** **	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)
	**Tobacco cessation drugs and products ** **	No charge
	**FDA approved contraceptive drugs and devices ** **	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply) ▼
	Other drug therapy services	
	• Home IV/Infusion therapy **	No charge
	• Medically necessary growth hormone therapy • Prescribed inhalation therapy	Applicable cost shares apply. See applicable benefit sections†
	Routine immunizations	No charge
Obstetrical care, interrupted pregnancy, family planning, in vitro fertilization, and sterilization services	**Routine obstetrical (maternity) care ** **	
	• Routine prenatal visits	No charge
	• Routine postpartum visit	No charge
	• Delivery/hospital stay (uncomplicated)	10% of applicable charges
	Non-routine obstetrical (maternity) care, including complications of pregnancy and false labor	Applicable cost shares apply. See applicable benefit sections†
	Inpatient stay and inpatient care for newborn, including circumcision and nursery care, during or after mother's hospital stay (assuming newborn is timely enrolled on Kaiser Permanente subscriber's plan)	Hospital inpatient care cost shares apply (see hospital inpatient care section)
	**Interrupted pregnancy ** **	$20 per visit

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Section	Benefits	You pay
	Family planning office visits for female members that are provided in accordance with the Patient Protection and Affordable Care Act	No charge
	All other family planning office visits	$20 per visit
	*** In vitro fertilization (IVF)**	20% of applicable charges
	Sterilization services • Vasectomy services	Applicable cost shares apply. See applicable benefit sections†
Reconstructive surgery	**Surgery to improve physical function**, such as bariatric surgery and surgery to correct congenital anomalies **Surgery following injury or medically necessary surgery** **Surgery following mastectomy**, including treatment for complications resulting from a covered mastectomy and reconstruction, such as lymphedema	Applicable cost shares apply. See applicable benefit sections†
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 copays apply to physician visits)
	Hospice care **	No charge (office visit copays apply to physician visits)
Skilled nursing care *	**Skilled nursing care ****	10% of applicable charges, up to 120 days per year
Emergency services	**Emergency services **** within and outside the Hawaii service area *Note: The copayment for emergency services is waived if you are directly admitted as a hospital inpatient from the emergency department (the hospital copay will apply).*	$100 per visit
Urgent care services	**Urgent care services **** • At a Kaiser Permanente (or Kaiser Permanente-designated) urgent care center within the Hawaii service area, for primary care services • At a Kaiser Permanente (or Kaiser Permanente-designated) urgent care center within the Hawaii service area, with a specialist • At a non-Kaiser Permanente facility outside the Hawaii service area	 $20 per visit $20 per visit 20% of applicable charges
Ambulance services	**Ambulance services ****	20% of applicable charges
Blood	**Blood and blood processing ****	Applicable cost shares apply. See applicable benefit sections†
Mental health services **	**Mental health** outpatient services, including office visits, day treatment and partial hospitalization services	$20 per visit
	Mental health hospital inpatient care, including non-hospital residential services	10% of applicable charges
Chemical dependency services **	**Chemical dependency** outpatient services, including office visits, day treatment and partial hospitalization services	$20 per visit
	Chemical dependency hospital inpatient care, including non-hospital residential services and detoxification services	10% of applicable charges
Health education	General **health education services ****, including diabetes self-management training and education	$20 per visit

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Section	Benefits	You pay
Dependent child coverage outside the service area **	While outside of the Kaiser Permanente's service areas, a dependent child is covered per year for the following services:	
	• Up to 10 office visits for routine primary care	$20 per visit
	• Up to 10 combined outpatient basic laboratory services, basic imaging services, and testing services	
	• Basic laboratory services	$10 per day
	• Basic imaging services	$10 per day
	• Testing services	20% of applicable charges
	• Up to 10 prescriptions of self-administered drugs	20% of applicable charges
Internal prosthetics, devices, and aids **	**Implanted internal prosthetics**, including fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss	Applicable cost shares apply. See applicable benefit sections†
Durable medical equipment **	**Diabetes equipment**	50% of applicable charges
	Home phototherapy equipment for newborns	No charge
	Breast feeding pump, including any equipment that is required for pump functionality	No Charge
	All other **durable medical equipment**	20% of applicable charges
External prosthetic devices and braces **	**External prosthetic devices and braces**	20% of applicable charges
	A prosthetic device following mastectomy, if all or part of a breast is surgically removed for medically necessary reasons *Note: Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.*	Applicable internal prosthetics, devices, and aids cost shares apply
Hearing aids **	**Hearing aids**, provided once every 36 months for each hearing impaired ear	60% of applicable charges
Other medical services and supplies	**Anesthesia and hospital services for dental procedures for children with serious mental, physical, or behavioral problems** **Pulmonary rehabilitation** **Hyperbaric oxygen therapy** **Anesthesia services**, including general anesthesia, regional anesthesia, and monitored anesthesia for high-risk members **Orthodontic services for treatment of orofacial anomalies** resulting from birth defects or birth defect syndromes **	Applicable cost shares apply. See applicable benefit sections†

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Section	Benefits	You pay
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: 1) 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), or 2) 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.	

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***** See **Coverage Exclusions** Section

****** See **Coverage Limitations** Section

* Coverage exclusions

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 orthopedic aids, corrective lenses and eyeglasses. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, external prosthetic devices, braces, and hearing aids may be covered benefits). Corrective lenses and eyeglasses may be covered for certain medical conditions, if all essential health benefits are required to be covered. Pediatric vision care services and devices may also be covered as an essential health benefit. (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,** including pediatric oral care, such as dental x-rays, dental implants, dental appliances, or orthodontia and Services relating to Craniomandibular Pain Syndrome. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, Services relating to temporomandibular joint dysfunction (TMJ) may be covered). (Part of this exclusion may not apply if you have a Dental 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 and vision therapy, including orthoptics, visual training and **eye exercises**. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, habilitative services and pediatric vision care services may be covered). (Eye exams for contact lens may be partially covered if you have an Optical Rider.)
- **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. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, vision procedures for certain medical conditions may be covered).
- **Routine foot care**, unless medically necessary.
- **Health education:** specialized health promotion classes and support groups (such as weight management and bariatric surgery program).
- **Homemaker Services**.
- **Infertility services** including services related to conception by artificial means (such as ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)), services to reverse voluntary, surgically-induced infertility, and stand-alone ovulation induction Services.
- **In vitro fertilization (IVF)** is limited to a one-time only benefit at Kaiser Permanente. Additional IVFs are not covered. In vitro fertilization must meet state law requirements, and Health Plan and Medical Group requirements and criteria. The cost of donor sperm, donor eggs, equipment and of collection, storage and processing of sperm or eggs are not covered.
- **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.

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- Long term **physical therapy, occupational therapy, speech therapy;** maintenance therapies; cardiac rehabilitation; unskilled therapy and physical, occupational, and speech therapy deficits due to developmental delay.
- **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 practitioners' services for treatment of sexual dysfunction.
- Personal comfort items, such as telephone, television, and take-home medical supplies, during covered **skilled nursing care.**
- **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

Benefits and Services are subject to the following limitations:

- 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 Kaiser Permanente physicians believe no professionally acceptable alternative treatment exists. Coverage will cease at the point the member stops following the recommended treatment.
- **Ambulance services** are those services which: 1) 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 2) 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.
- **Autism services** are limited to: 1) diagnosis and treatment of autism, and 2) applied behavioral analysis services. Treatment for autism will be provided in accord with an approved treatment plan. The following are excluded from coverage: 1) services provided by family or household members, and 2) autism services that duplicate services provided by another therapy or available through schools and/or government programs.
- Coverage of **blood and blood processing** includes (regardless of replacement, units and processing of units) whole blood, red cell products, cryoprecipitates, platelets, plasma, and fresh frozen plasma. Rh immune globulin is provided subject to the cost share for skilled-administered prescription drugs. Coverage of blood and blood processing also includes 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.
- **Chemical dependency services** include coverage in a specialized alcohol or chemical dependence treatment unit or facility approved by Kaiser Permanente Medical Group. Specialized alcohol or chemical dependence treatment services include day treatment or partial hospitalization services and non-hospital residential services. All covered chemical dependency services will be provided under an approved individualized treatment plan.
- Members are covered for **contraceptive drugs and devices** (to prevent unwanted pregnancies) only when all of the following criteria are met: 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.
- When applicable, the **deductible** is the amount that members must pay for certain services before Health Plan will cover those services. Services that are subject to the deductible are noted in the "You Pay" column of this benefit summary (for example, if "after deductible" is noted in the "You Pay" column after the copayment, then members or family units must meet the deductible before the noted copayment will be effective). This deductible is separate from any other benefit-specific deductible that may be described

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herein. For example if prescription drugs are subject to a drug deductible, payments toward that drug deductible do not count toward this medical deductible. Payments toward this medical deductible do not count toward any other benefit-specific deductible (such as a drug deductible). Services that are subject to this medical deductible are: 1) outpatient surgery or procedures provided in an ambulatory surgery center (ASC) or other hospital-based setting, 2) hospital inpatient care, 3) specialty laboratory services, 4) specialty imaging services, 5) skilled nursing care, and 6) emergency services (when noted).

- 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.
- **Prescribed drugs that require skilled administration by medical personnel** must meet all of the following: 1) prescribed by a Kaiser Permanente licensed prescriber, 2) on the Health Plan formulary and used in accordance with formulary guidelines or restrictions, and 3) prescription is required by law.
- **Durable medical equipment** (such as oxygen dispensing equipment and oxygen, diabetes equipment, home phototherapy equipment for newborns, and breast feeding pump) must be prescribed by a Kaiser Permanente or Kaiser Permanente-designated physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Kaiser Permanente on either a purchase or rental basis, as determined by Kaiser Permanente. Durable medical equipment 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 Kaiser Permanente's formulary and used in accordance with formulary criteria, guidelines, or restrictions. Repair, replacement and adjustment of durable medical equipment, other than due to misuse or loss, is included in coverage. **Diabetes equipment** is limited to glucose meters and external insulin pumps, and the supplies necessary to operate them. Coverage of **breast feeding pump** includes any equipment that is required for pump functionality. If rented or loaned from Kaiser Permanente, the member must return any durable medical equipment items to Kaiser Permanente or its designee or pay Kaiser Permanente or its designee the fair market price for the equipment when it is no longer prescribed by a Kaiser Permanente 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. The following are excluded from coverage: 1) comfort and convenience equipment, and devices not medical in nature such as sauna baths and elevators, 2) disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages, 3) exercise and hygiene equipment, 4) electronic monitors of the function of the heart or lungs, 5) devices to perform medical tests on blood or other body substances or excretions, 6) dental appliances or devices, 7) repair, adjustment or replacement due to misuse or loss, 8) experimental or research equipment, 9) durable medical equipment related to sexual dysfunction, and 10) modifications to a home or car.
- **Emergency services** are covered for initial emergency treatment only. 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. 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, heavy bleeding, sudden weakness on one side, severe pain, breathing problems, drug overdose, severe allergic reaction, severe burns, and broken bones. Examples on non-emergencies are colds, flu, earaches, sore throats, and using the emergency room for convenience or during normal office hours for medical conditions that can be treated in a medical office. Continuing or follow-up treatment for Emergency Medical Conditions at a non-Kaiser Permanente facility is not covered.
- When applicable, **essential health benefits** are provided to the extent required by law and include ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services to the extent required by HHS and EHB-benchmark plan. Pediatric oral care services are covered under this Service Agreement only if a separate Dental Rider is attached (covered services are described within any applicable Dental Rider). A complete list of essential health benefits is available through Member Services. Essential health benefits are provided upon payment of the copayments listed under the appropriate benefit sections (e.g. – office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.).
- **External prosthetic devices and braces** (including speech generating devices and voice synthesizers) must be prescribed by a Kaiser Permanente physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Kaiser Permanente. External prosthetic devices must meet all of the following criteria: 1) are affixed to the body externally, 2) 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

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organ, 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 prosthetic is prescribed. Fitting and adjustment of these devices, including repairs and replacement other than due to misuse or loss, is included in coverage. Covered **braces** are those rigid and semi-rigid devices which: 1) are required to support a weak or deformed body member, or 2) are required to restrict or eliminate motion in a diseased or injured part of the body, and 3) 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. The following items are not covered as external prosthetics, but may be covered under another benefit category: 1) pacemakers and other surgically implanted internal prosthetic devices (these are covered under implanted internal prosthetic devices and aids), 2) hearing aids (these are covered under the hearing aid benefit), and 3) corrective lenses and eyeglasses (these are covered under any applicable pediatric vision care service and may also be covered if an Optical Rider is attached). The following items are excluded from coverage: 1) dental prostheses, devices and appliances, 2) non-rigid appliances such as elastic stockings, garter belts, arch supports, non-rigid corsets and similar devices, 3) orthopedic aids such as corrective shoes and shoe inserts, 4) replacement of lost prosthetic devices, 5) repairs, adjustments or replacements due to misuse or loss, 6) experimental or research devices and appliances, 7) external prosthetic devices related to sexual dysfunction, 8) supplies, whether or not related to external prosthetic devices or braces, 9) external prosthetics for comfort and/or convenience, or which are not medical in nature, and 10) disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages. 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.

- When covered as a preventive care service (under the Patient Protection and Affordable Care Act), 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.
- General **health education services** include patient education classes which are educational programs directed toward members who have specific diagnosed medical conditions whereby members are taught self-care skills to understand, monitor, manage and/or improve their condition. Examples of conditions include asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and behavioral health conditions.
- **Hearing aids** must be prescribed by a Kaiser Permanente physician or Kaiser Permanente audiologist and obtained from sources designated by Kaiser Permanente. Coverage is limited to the lowest priced model hearing aid(s). Hearing aid(s) above the lowest priced model will be provided upon payment of the copayment that member 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). All other related costs are excluded from coverage, including but not limited to consultation, fitting, rechecks and adjustments for the hearing aid(s).
- Prescription drugs that are self-administered intravenously under the **home IV/infusion** benefit include biological therapeutics, biopharmaceuticals, or intravenous nutrient solutions needed for primary diet. Self-administered injections are covered upon payment of the member cost share for take-home, self-administered prescription drugs.
- Coverage of **hospice care** is 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: 1) nursing care (excluding private duty nursing), 2) medical social services, 3) home health aide services, 4) medical supplies, 5) physician services, 6) counseling and coordination of bereavement services, 7) services of volunteers, and 8) physical therapy, occupational therapy, or speech language pathology.
- **Hospital inpatient care** (for acute care registered bed patients) includes services such as: 1) room and board, 2) general nursing care and special duty nursing, 3) physicians' services, 4) surgical procedures, 5) respiratory therapy and radiation therapy, 6) anesthesia, 7) medical supplies, 8) use of operating and recovery rooms, 9) intensive care room, 10) isolation care room, 11) medically necessary services provided in an intermediate care unit at an acute care facility, 12) special diet, 13) laboratory services, 14) imaging services, 15) testing services, 16) radiation therapy, 17) chemotherapy, 18) physical therapy, 19) occupational therapy, 20) speech therapy, 21) administered drugs, 22) internal prosthetics and devices, 23) blood, 24) durable medical equipment ordinarily furnished by a hospital, and 25) external prosthetic devices and braces ordinarily furnished by a hospital.
- 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) must be prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan. Internal prosthetics, devices, and aids 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

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and guidelines established by Medicare at the time the device is prescribed. Fitting and adjustment of these devices, including repairs and replacement other than due to misuse or loss, is included in coverage. The following are excluded from coverage: a) all implanted internal prosthetics and devices and internally implanted aids related to an excluded or non-covered service/benefit, and b) 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.

- The following **interrupted pregnancies** are included: 1) medically indicated abortions, and 2) elective abortions (including abortion drugs such as (RU-486). Elective abortions are limited to two per member per lifetime.
- Specialty **laboratory services** include tissue samples, cell studies, chromosome studies, pathology, and testing for genetic diseases. Basic **laboratory services** include services such as thyroid tests, throat cultures, urine analysis, fasting blood sugar and A1c for diabetes monitoring, electrolytes, drug screening, blood type and cross match, cholesterol tests, and hepatitis B.
- A service or item is **Medically Necessary** (subject to the applicable state law definitions and criteria) only if, 1) recommended by the treating 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. If no scientific evidence exists, then by professional standards of care. If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion.
- **Mental health services** include coverage in a specialized mental health treatment unit or facility approved by Kaiser Permanente Medical Group. Specialized mental health treatment services include day treatment or partial hospitalization services and non-hospital residential services. All covered mental health services will be provided under an approved individualized treatment plan.
- **Office visits** are limited to one or more of the following services: examination, history, medical decision making and/or consultation. Members' choice of primary care providers and access to specialty care allow for the following: 1) member may choose any primary care physician available to accept member, 2) parents may choose a pediatrician as the primary care physician for their child, 3) members do not need a referral or prior authorization for certain specialty care, such as obstetrical or gynecological care, and 4) the physician may have to get prior authorization for certain services. A **Specialist** is a licensed medical practitioner identified by Health Plan or Medical Group, including a Kaiser Permanente physician, except does not include (i) family practice, (ii) general practice, (iii) internal medicine, (iv) pediatrics, (v) obstetrics/gynecology (including certified nurse midwives), (vi) physician assistants (PA), and (vii) Health Plan employed providers. Members must obtain a referral for most initial visits in order to receive covered services from certain Specialists.
- **Orthodontic services for treatment of orofacial anomalies** resulting from birth defects or birth defect syndromes are limited to Members under 26 years of age, and to a maximum benefit per treatment phase set annually by the insurance commissioner for the applicable calendar year. For example, for 2016 contracts, Member will be responsible for all charges after Health Plan has paid the maximum benefit of $5,500 per treatment phase.
- 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) services means medical services provided for those conditions which meet all of the following criteria: 1) the therapy is ordered by a Physician under an individual treatment plan; 2) in the judgment of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy; 3) the therapy is provided by or under the supervision of a Physician-designated licensed physical, speech, or occupational therapist, as appropriate.; and 4) as determined by a Physician, the therapy must be skilled and necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury. **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.
- **Radiation therapy** services include radium therapy, radioactive isotope therapy, specialty imaging and skilled administered drugs.
- In accordance with **routine obstetrical (maternity) care,** 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.
- Covered **skilled nursing care** in an approved facility (such as a hospital or skilled nursing facility) includes the following services: 1) nursing care, 2) room and board (including semi-private rooms), 3) medical social services, 4) medical supplies, 5) durable medical equipment ordinarily provided by a skilled nursing facility, 6) external prosthetic devices and braces ordinarily furnished by a skilled nursing facility, 7) radiation therapy, and 8) chemotherapy. 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.
- Services covered under the **dependent child coverage outside the service area** benefit are subject to the following limitations: 1) services can only be obtained outside Kaiser Permanente Hawaii's service area and outside all other Kaiser Permanente's service areas, at non-Kaiser Permanente facilities and with non-Kaiser Permanente health care providers, 2) the dependent child must pay for services at the point in time the services are received then file a claim for reimbursement by submitting the claim to Kaiser Permanente's claims department, 3) this dependent child coverage benefit cannot be combined with any other

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benefit, 4) Kaiser Permanente will not pay under this dependent child coverage benefit for a service Kaiser Permanente is covering under another section, such as emergency services, out of area urgent care, and referrals, and 5) this dependent child coverage benefit does not apply to Senior Advantage members and Medicare members with Medicare as primary coverage. The following are excluded under the dependent child coverage outside the service area benefit: 1) transplant services and related care, 2) services received outside the United States, 3) services other than routine primary care, basic laboratory services, basic imaging services, testing services, and self-administered prescription drugs, 4) outpatient surgery and procedures performed in an ambulatory surgery center or other hospital-based setting, 5) services received in other Kaiser Permanente regions' service areas, 6) services received within Kaiser Permanente Hawaii's service area, 7) dental, 8) mail order drugs, 9) chiropractic, acupuncture and massage therapy services, and 10) services not explicitly listed as covered under this dependent child coverage benefit.

- Your incurred copays and coinsurance for covered medical Basic Health Services are capped each year by a medical **supplemental charges maximum**.
  - All incurred copays, coinsurance, and deductibles (if applicable) count toward the limit on supplemental charges, and are credited toward the year in which the medical services were received.
  - Supplemental charges for the following Basic Health Services can be applied toward the supplemental charges maximum, if the item or service is covered under this Service Agreement: office visits for services listed in this Basic Health Services section, allergy test materials, ambulance service, blood or blood processing, braces, chemical dependency services, contraceptive drugs and devices, payments toward any applicable deductible, dependent child coverage outside the service area, diabetes supplies and equipment, dialysis, drugs requiring skilled administration, durable medical equipment, emergency service, external prosthetics, family planning office visits, health evaluation office visits for adults, hearing aids, home health, hospice, imaging (including X-rays), immunizations (excluding travel immunizations), internal prosthetics, internal devices and aids, in vitro fertilization procedure, inpatient room (semi-private), interrupted pregnancy/abortion, laboratory, medical foods, mental health services, obstetrical (maternity) care, outpatient surgery and procedures, radiation and respiratory therapy, radioactive materials, reconstructive surgery, covered self-administered/outpatient prescription drugs (including payments toward any applicable prescription drug deductible), short-term physical therapy, short-term speech therapy, short-term occupational therapy, skilled nursing care, testing services, transplants (the procedure), and urgent care.
  - The following services are <u>not</u> 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, complementary alternative medicine (chiropractic, acupuncture, massage therapy, or naturopathy), dental services, dressings and casts, handling fee or taxes, health education services, classes or support groups, medical social services, office visits for services which are not Basic Health Services, take-home supplies, and travel immunizations.
- **Testing services** include electrocardiograms, electroencephalograms, EMG, pulmonary function studies, sleep studies, and treadmill.
- Up to a 30-consecutive-day supply of **tobacco cessation drugs and products** is provided when all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) 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, 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, and 4) 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 year, unless medically necessary.
- **Transplant services** and **transplant evaluations** for transplant donors. Covered transplants include kidney, pancreas, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel, small bowel-liver transplants, small bowel and multivisceral transplants, and stem-cell transplants. 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 <u>courtesy</u> 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 donation.

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- 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.

- **Urgent care services** are covered for initial urgent care treatment only. "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.

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.

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Domestic partner coverage	A Domestic Partner who meets the Domestic Partner eligibility requirements may enroll as a Subscriber's Family Dependent. The Subscriber and Subscriber's Domestic Partner must fill out a Domestic Partner Affidavit and return it to Kaiser Permanente. This information is subject to prior verification by Kaiser Permanente.

Kaiser Permanente Fit Rewards® Program provides these extra services

Kaiser Permanente Fit Rewards– Calendar Year

Basic Program fitness club and exercise center membership program — **No charge**

- Eligible members may enroll with and American Specialty Health, Inc. (ASH) contracted network fitness club
- Program enrollment includes standard fitness club services and features
- Eligible Members should verify services and features with ASH contracted fitness club

Note:

- Eligible members must pay the Fit Rewards $200 annual program fee✦
- Eligible members must meet the 45-day, 30-minute per session activity requirement by end of 2017

Or

Home Fitness Program — **$10**

- Eligible Members may select up to two of the available ASH home fitness kits per year

Active&Fit website

- All eligible Members have access to Active&Fit web-based services such as facility provider search, enrollment functions, educational content and fitness tools and trackers.

The following are excluded from Active&Fit Program:

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

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

Kaiser Permanente FIT REWARDS

Frequently Asked Questions

What is Kaiser Permanente Fit Rewards?

Kaiser Permanente Fit Rewards is a new value-added program offering Kaiser Permanente Hawaii members the opportunity to earn a free gym membership.[1]

Who is eligible for Kaiser Permanente Fit Rewards?

All Kaiser Permanente Hawaii members 16 years and older, except Medicare and QUEST Integration (Medicaid) members, are eligible.[2]

When does Kaiser Permanente Fit Rewards start?

Kaiser Permanente Fit Rewards starts January 1, 2017.

How does Kaiser Permanente Fit Rewards work?

- If you're an eligible Kaiser Permanente member, choose a participating gym. Search the full list of participating gyms at **kp.org/fitrewards**.
- Pay an annual program fee (up to $200) directly to the gym.[3]
  Note: If you're currently a 24 Hour Fitness member or would like to join 24 Hour Fitness, visit **kp.org/activeandfit** or call toll-free **1-877-750-2746** (TTY/TDD **1-877-710-2746**), Monday through Friday, 5 a.m. to 3 p.m. Hawaii time, to pay your annual program fee.
- Work out at a participating gym at least 45 days for a minimum of 30 minutes per session by the end of 2017.[1] Your gym will report your activity to Active&Fit.
- If you meet the activity requirement by the end of 2017, you'll get your annual program fee back.[1]

Is Kaiser Permanente Fit Rewards the same as the Active&Fit Basic Program?

No. **Kaiser Permanente Fit Rewards** adds a brand new reimbursement option that essentially allows you to have a free gym membership[1] through the Active&Fit program. This free gym membership[1] feature is available only to Kaiser Permanente Hawaii members.

The Active&Fit Basic program provides Active&Fit members access to a gym membership through a broad network of participating gyms to individual and group health plan members. It also has a Home Fitness option for those who physically cannot or prefer not to go to a gym.

Kaiser Permanente Fit Rewards and the Active&Fit Basic program are provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH).

How do I get started if I already participate in the Active&Fit Basic program?

If you're a current Active&Fit member, you can renew your membership at a participating gym and pay your annual program fee directly to the gym. You also can switch gyms if the facility is in the Active&Fit network.

If you're a 24 Hour Fitness member, pay Active&Fit directly by visiting **kp.org/activeandfit** or calling the Active&Fit customer service toll free at **1-877-750-2746** (TTY/TDD **1-877-710-2746**), Monday through Friday, 5 a.m. to 3 p.m., Hawaii time.

Active&Fit®

KAISER PERMANENTE® thrive

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Kaiser Permanente FIT REWARDS FAQ

How do I get started if I do not currently participate in Active&Fit?

Starting January 1, 2017, if you're an eligible Kaiser Permanente Hawaii member, you can join a participating gym and pay your annual program fee directly to the gym.

If you want to join 24 Hour Fitness, pay Active&Fit directly by visiting **kp.org/activeandfit** or calling the Active&Fit customer service toll free at **1-877-750-2746** (TTY/TDD **1-877-710-2746**), Monday through Friday, 5 a.m. to 3 p.m., Hawaii time.

Where can I find a list of participating gyms?

Starting October 1, 2016, visit **kp.org/fitrewards** to see the full list of participating gyms. You also can call Active&Fit customer service toll free at **1-877-750-2746** (TTY/TDD, **1-877-710-2746**), Monday through Friday, 5 a.m. to 3 p.m.

PARTICIPATING GYMS

What if I want to go to a gym that is not part of the Active&Fit network?

Members can request the addition of gyms and fitness facilities online at **kp.org/activeandfit** or by calling the Active&Fit customer service hotline at **1-877-750-2746**.

Can I switch gyms?

Yes. You can switch gyms by going online at **kp.org/activeandfit** or by calling Active&Fit customer service at **1-877-750-2746**.

If I switch gyms, do I have to pay my annual program fee again?

No. You do not need to pay your annual fee again unless it's a new benefit year.

If I switch gyms, how soon can I go to my new gym?

You can go to your new gym on the first day of the following month.

REIMBURSEMENT

Are taxes and any additional fees I paid to my gym eligible for reimbursement?

No. If you successfully meet the activity requirement by the end of 2017, your reimbursement is limited to your annual program fee. Taxes and any additional charges or fees you pay your gym for classes, services, or amenities are not included in the program and are not eligible for reimbursement.[1]

If I change gyms during the year and meet the 45-day, 30-minute per session activity requirement, will I receive reimbursement?

Yes. Your total number of visits count toward the 45-day, 30-minute per session activity requirement, as long as you go to gyms in the Active&Fit network.

What if I am physically unable or prefer not to go to a gym?

You can choose to participate in the Active&Fit Home Fitness program, instead of attending a participating gym. For a $10 annual program fee, you can choose up to 2 home fitness kits and work out anytime at home. The fitness kits may include DVDs, guides, and other items to help you get fit.

Note: If you participate in the Active&Fit Home Fitness program, your $10 annual program fee is non-refundable and will not be prorated. You are not eligible for reimbursement of your $10 annual fee.

[1]Reimbursement is limited to your Active&Fit annual program fee each benefit year. Taxes and additional charges you pay your gym for classes, services, or amenities are not included in the Active&Fit program and are not eligible for reimbursement. Please refer to your *Benefit Summary* or **kp.org/fitrewards** for details, including conditions, limitations, and exclusions.

[2]The Active&Fit website is available for members who are 18 years and older.

[3]Except for earning your annual program fee back by exercising 45 days a year for at least 30 minutes, your annual fee is not refundable and will not be prorated.

Kaiser Permanente Fit Rewards is a value-added service and not part of your medical benefits. Your annual fee does not count toward your health plan's annual out-of-pocket maximum. For details, see your *Benefit Summary* or **kp.org/fitrewards**.