KAISER PERMANENTE®

**KP Added Choice 2011 80%/20% Plan**
**Prevalent POS - Rx, CAM, $15 OVC, $50 ER/Hosp**
**• kp.org**

# 2018 Features of your Kaiser Permanente Added Choice Group Plan

| Benefit | In-network Kaiser Permanente Member pays | Out-of-network † Kaiser Permanente Insurance Company Member pays | |
|---|---|---|---|
| **Deductible** | None | $100/$300 | |
| **Out-of-pocket maximum** | N/A | $2,000/$6,000 | |
| **Annual supplemental charges maximum** (individual/family unit of 3 or more members) | $2,000/$6,000 | N/A | |
| | **In-network Kaiser Permanente** | **Contracted provider** | **Non-contracted provider** |
| **Preventive services** | | | |
| Well-child office visits (birth through age 5) | No charge | Covered at 100% of MAC* | Covered at 100% of MAC* |
| Routine Immunizations | No charge | Covered at 100% of MAC* | Covered at 100% of MAC* |
| One preventive office visit per calendar year (age 6 and older) | No charge | 20% of MAC* | 20%of MAC* |
| One gynecological office visit per calendar year (for female members) | No charge | 20% of MAC* | 20%of MAC* |
| **Outpatient services** | | | |
| Primary care office visits | $15 per visit | 20% of MAC* | 20% of MAC* |
| Specialty care office visits | $15 per visit | 20% of MAC* | 20% of MAC* |
| Routine obstetrical (maternity) care | No charge | 20% of MAC* | 20% of MAC* |
| **Inpatient services** | | | |
| Hospital room and board, doctors, medical and surgical services, and anesthesia services | $50 per day observation and maternity stay no charge | 20% of MAC* | 20% of MAC* |
| **Laboratory, imaging, and testing services** | | | |
| Inpatient lab, imaging and testing | Included in hospital copay | 20% of MAC* | 20% of MAC* |
| Outpatient lab, imaging and testing | 10% of applicable charges for basic labs and imaging 10% for complex labs and imaging 10% for testing | 20% of MAC* | 20% of MAC* |
| **Mental health services** | | | |
| Outpatient office visits | $15 per visit | 20% of MAC* | 20% of MAC* |
| Hospital inpatient care | $50 per day | 20% of MAC* | 20% of MAC* |
| Day treatment or partial hospitalization services | $15 per visit | 20% of MAC* | 20% of MAC* |
| Non-hospital residential services | $50 per day | 20% of MAC* | 20% of MAC* |

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC.

This document is to be used for marketing purposes only. It is a summary and does not fully describe your benefit coverage. Please refer to your group detailed benefit summary for more details on your benefit coverage, exclusions, limitations, and plan terms. For additional information please also refer to your employer, to *Our physicians and locations* directory for practitioner and provider availability, and to your *Member handbook*.

| Benefit | In-network Kaiser Permanente Member pays | Out-of-network † Kaiser Permanente Insurance Company Member pays | |
|---|---|---|---|
| | In-network Kaiser Permanente | Contracted provider | Non-contracted provider |
| **Chemical dependency services** | | | |
| Outpatient office visits | $15 per visit | 20% of MAC* | 20% of MAC* |
| Hospital inpatient care | $50 per day | 20% of MAC* | 20% of MAC* |
| Day treatment or partial hospitalization services | $15 per visit | 20% of MAC* | 20% of MAC* |
| Non-hospital residential services | $50 per day | 20% of MAC* | 20% of MAC* |
| **Emergency services (for initial treatment only)** | | | |
| Within the Hawaii service area | $50 copay | N/A | N/A |
| Outside the Hawaii service area | $50 copay | N/A | N/A |
| **Ambulance services** | 20% of applicable charges | 20% of MAC* | 20% of MAC* |
| **Diabetes equipment and internal prosthetics, devices and aids** | | | |
| Diabetes suplies | 50% of applicable charges | 20% of MAC* | 20% of MAC* |
| Internal prosthetics, devices and aids | Follows applicable benefit category | 20% of MAC* | 20% of MAC* |
| **External prosthetics, durable medical equipment** | 20% of applicable charges | 20% of MAC* | 20% of MAC* |
| **Hearing Aid** | 60% of applicable charges | Not covered | Not covered |
| Lowest priced model, per ear, every 36 months | | | |

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC.

This document is to be used for marketing purposes only. It is a summary and does not fully describe your benefit coverage. Please refer to your group detailed benefit summary for more details on your benefit coverage, exclusions, limitations, and plan terms. For additional information please also refer to your employer, to *Our physicians and locations* directory for practitioner and provider availability, and to your *Member handbook*.

| Benefit | In-network<br>Kaiser Permanente<br>Member pays | Out-of-network †<br>Kaiser Permanente Insurance Company<br>Member pays | |
|---|---|---|---|
| | **In-network<br>Kaiser Permanente** | **Contracted<br>provider** | **Non-contracted<br>provider** |
| **4-Tier Prescription drug 3/15/50/200**<br>Per prescription | Generic maintenance drugs: $3<br>Other Generic Drugs: $15<br>Brand-Name Drugs: $50<br>Specialty drugs: $200 | 20% of charge but not less than stated copay value per prescription of each given category (limited to 30 day supply per prescription) | Not covered |
| **Prescription drug mail-order incentive** | Two drug copayments<br>for a 90-consecutive-day<br>supply | N/A | N/A |
| **Complementary Alternative Medicine<br>Chiropractic, acupuncture,<br>and massage services**<br>(up to 20 visits per calendar year) | (Provided by American Specialty Health Services)<br>$20 per visit | | |
| **Fit Rewards**<br>per calendar year | $200 gym membership or<br>$10 home fitness program | | |

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC.

This document is to be used for marketing purposes only. It is a summary and does not fully describe your benefit coverage. Please refer to your group detailed benefit summary for more details on your benefit coverage, exclusions, limitations, and plan terms. For additional information please also refer to your employer, to *Our physicians and locations* directory for practitioner and provider availability, and to your *Member handbook*.

## Kaiser Permanente Added Choice with 80%/20% Out-of-Network Plan
## 2018 Benefits Summary

**This is only a summary.** It does not fully describe your benefit coverage. For complete details on your benefit coverage, exclusions, limitations, 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"), and the Kaiser Permanente Insurance Company (KPIC) Group Policy and Certificate of Insurance. The Service Agreement and KPIC Group Policy are the legal binding documents between Health Plan, KPIC, and your employer. In event of ambiguity, or a conflict between this summary and the Service Agreement and KPIC Group Policy, the Service Agreement and KPIC Group Policy shall control.

You are covered for Medically Necessary covered services as defined under Service Agreement and KPIC Certificate of Insurance.

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

*In-Network only: 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, 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.*

| Coverage limits | | In-network Kaiser Permanente | Out-of-network † Kaiser Permanente Insurance Company |
|---|---|---|---|
| **General Provisions** | **Annual deductible** must be satisfied before benefits are payable, unless otherwise waived | None | $100 per member<br>$300 per family unit |
| | **Lifetime maximum benefit while insured** | None | None |
| | **Utilization management/precertification** | 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.<br>Note: all references to "physician" refer to a Kaiser Permanente physician. | Precertification is required three days prior to receiving select services as listed in the KPIC Certificate of Insurance. If precertification is not obtained, benefits otherwise payable will be reduced by $300 each time precertification is required and not obtained, up to a maximum penalty of $1,000 per year. Please consult your Certificate of Insurance for the current list of services requiring preauthorization. |

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

| Coverage limits | | In-network<br>Kaiser Permanente | Out-of-network †<br>Kaiser Permanente Insurance Company |
|---|---|---|---|
| **General Provisions** continued | **Supplemental Charges Maximum and Out-of-Pocket Maximum** | **Kaiser Permanente Supplemental Charges Maximum**<br>$2,000/$6,000 | **Out-of-Pocket Maximum** |
| | | Your incurred copays and coinsurance for covered Basic Health Services are capped each year by a **supplemental charges maximum.** Except dental services covered by Hawaii Dental Services, 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.<br>**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, 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), prescription drug coverage outside the service area, short-term physical therapy, short-term speech therapy, short-term occupational therapy, skilled nursing care, testing services, transplants (the procedure), and urgent care.<br>The following services 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, complementary alternative medicine (chiropractic, acupuncture, massage therapy, or naturopathy services), 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. | $2,000 per member, $6,000 per family unit (3 or more members)<br>*For a Member*: When a Member's share of Covered Charges incurred equals the Out-of-Pocket Maximum (**shown in the Schedule of Coverage**) during a year, the Percentage Payable will increase to 100 percent of further Covered Charges incurred by that same Member during the remainder of that year.<br>*For a Family*: When the amount of Covered Charges incurred by all covered family members equals the Out-of-Pocket Maximum (**shown in the Schedule of Coverage**) during a year, the Percentage Payable will increase to 100 percent of further Covered Charges incurred by covered family members during the remainder of that year.<br><br>Any part of a charge that does not qualify as a Covered Charge, will not be applied toward satisfaction of the Out-of-Pocket Maximum. |

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits | In-network | Out-of-network † Kaiser Permanente Insurance Company | |
|---|---|---|---|
| See also benefit exclusions and limitations lists. | Kaiser Permanente | Contracted Provider | Non-contracted provider |
| | Member pays | Member pays | |
| **Outpatient Services** | | | |
| **Office visits** [2] are limited to one or more of the following services: examination, history, medical decision making and/or consultation) | | | |
| •**For primary care** | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| •**With a specialist** | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| **Outpatient surgery and procedures** | | | |
| •Provided in medical office during a primary care visit | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| •Provided in medical office with a specialist | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| •Provided in ambulatory surgery center (ASC) or hospital-based setting | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| •Routine pre- and post-surgical office visits in connection with a covered surgery | No charge | 20% of the MAC* | 20% of the MAC* |
| **Telehealth** | Applicable cost shares apply. See applicable benefit section†† | 20% of the MAC* | 20% of the MAC* |
| **Allergy Testing** | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| **Allergy Treatment Materials** that are on the in Network and out-of-Network drug formularies and require skilled administration by medical personnel | 20% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| **Chemotherapy**, includes the treatment of infections or malignant diseases | | | |
| • Office visits | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| • Chemotherapy infusions or injections that require skilled administration by medical personnel | 20% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| • Self-administered oral 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). | 20% of the MAC* | 20% of the MAC* |
| **Physical, occupational, and speech therapy[2]** | $15 per visit | 20% of MAC* limited to a combined maximum of 60 outpatient visits per calendar year. Therapy must be for a condition that is subject to significant improvement within two months. | |

[1] See **Coverage Exclusions for in-Network Services** section

[2] See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits<br>See also benefit exclusions and limitations lists. | In-network<br>Kaiser Permanente | Out-of-network †<br>Kaiser Permanente Insurance Company<br>Contracted Provider | <br><br>Non-contracted provider |
|---|---|---|---|
| | **Member pays** | **Member pays** | |
| **Autism services**** | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |
| **Dialysis** | | | |
| •Physician and facility services for dialysis | 20% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| •Equipment, training, medical supplies for home dialysis | No charge | 20% of the MAC* | 20% of the MAC* |
| **Materials for dressings and casts** | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |
| **Outpatient laboratory, imaging, and testing services** | | | |
| **Laboratory services[2]** | 10% of applicable charges for basic laboratory services and 10% of applicable charges for specialty laboratory services | 20% of the MAC* | 20% of the MAC* |
| **Imaging services[2]** | | | |
| • General radiology | 10% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| • Specialty imaging services | 10% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| **Testing services[2]** | 10% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| **Outpatient radiation therapy** | | | |
| **Radiation therapy[2]** | 20% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| **Observation** | | | |
| **Observation** | No charge | 20% of the MAC* | 20% of the MAC* |
| **Hospital inpatient care** (for acute care registered bed patients) | | | |
| **Hospital inpatient care[2]** | $50 per day | 20% of the MAC* | 20% of the MAC* |
| **[1]Physical, occupational and speech therapy[2]** | Included in the above hospital inpatient care cost share | 20% of the MAC* | 20% of the MAC* |

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits | In-network | Out-of-network † Kaiser Permanente Insurance Company | |
|---|---|---|---|
| See also benefit exclusions and limitations lists. | Kaiser Permanente | Contracted Provider | Non-contracted provider |
| | Member pays | Member pays | |
| **Transplants** | | | |
| **Transplants**[1] | Applicable cost shares apply. See applicable benefit sections†† | Not covered | Not covered |
| **Preventive care services (PPACA)** | | | |
| Preventive care services (which protect against disease, promote health, and/or detect disease in its earliest stages before noticeable symptoms develop) including:<br>• Screening services for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF), such as:<br>– Preventive counseling services<br>– Screening laboratory services<br>– Screening radiology services<br>• FDA approved contraceptive drugs and devices[2] that are available on the applicable 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.<br>• Female sterilizations[2]<br>• Purchase of breast feeding pump, including any equipment that is required for pump functionality<br>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. | No charge (non-preventive care services according to member's regular plan benefits) | No charge up to the MAC*, deductible waived (non-preventive care services according to member's regular plan benefits) | No charge up to the MAC*, deductible waived (non-preventive care services according to member's regular plan benefits) |
| **Preventive care services (non-PPACA)** | | | |
| • 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) | No charge | 20% of the MAC*, deductible waived | 20% of the MAC*, deductible waived |
| • One preventive care office visit per year for members 6 years of age and over | No charge | 20% of the MAC* | 20% of the MAC* |
| • One gynecological office visit per year for female members | No charge | 20% of the MAC* | 20% of the MAC* |

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits | In-network | Out-of-network † Kaiser Permanente Insurance Company | |
|---|---|---|---|
| See also benefit exclusions and limitations lists. | Kaiser Permanente | Contracted Provider | Non-contracted provider |
| | Member pays | Member pays | |
| **Prescribed drugs** | | | |
| **Prescribed drugs that require skilled administration by medical personnel,** such as injections and infusions (e.g. cannot be self-administered)2 | | | |
| • Provided in a medical office | 20% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| • Provided during other settings, such as hospital stay, outpatient surgery, skilled nursing care | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |
| Prescribed **Self-administered drugs** (such as drugs taken orally)/Outpatient prescription drugs | See attached Drug summary | See attached Drug summary | See attached Drug summary |
| **Diabetes supplies**[2] | 50% of applicable charges** (a minimum price as determined by Pharmacy Administration may apply) | 20% of the MAC* | 20% of the MAC* |
| **Tobacco cessation drugs and products**[2] | No charge | No charge up to the MAC*, deductible waived (if your group purchased a drug rider | No charge up to the MAC*, deductible waived |
| **FDA-approved contraceptive drugs and devices**[2] | 50% of applicable charges** (a minimum price as determined by Pharmacy Administration may apply) | No charge up to the MAC*, deductible waived (if your group purchased a drug rider | No charge up to the MAC*, deductible waived |

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits | In-network | Out-of-network † Kaiser Permanente Insurance Company | |
|---|---|---|---|
| See also benefit exclusions and limitations lists. | Kaiser Permanente | Contracted Provider | Non-contracted provider |
| | Member pays | Member pays | |
| **Other drug therapy services** | | | |
| • Home IV/Infusion therapy[2] | No charge | 20% of the MAC* | 20% of the MAC* |
| • Medically necessary growth hormone therapy | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |
| • Prescribed inhalation therapy | | | |
| **Routine immunizations** | No charge | No charge up to the MAC*, deductible waived | No charge up to the MAC*, deductible waived |

**Exclusions**

- Self-administered drugs/outpatient prescription (such as drugs taken orally) unless otherwise specifically set forth as a covered service.
- Drugs that are necessary or associated with services that are excluded or not covered

**Limitation:**

Diabetic drugs and insulin are covered by Kaiser Permanente Insurance Company (KPIC). Covered charges for diabetic drugs and insulin are limited to a 30-day consecutive supply per prescription or refill.

Your group may have purchased drug coverage for self-administered/outpatient prescription drugs under a separate rider. If so, it will be listed on the attached pages.

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits | In-network | Out-of-network † Kaiser Permanente Insurance Company | |
|---|---|---|---|
| See also benefit exclusions and limitations lists. | Kaiser Permanente | Contracted Provider | Non-contracted provider |
| | Member pays | Member pays | |
| **Obstetrical care, interrupted pregnancy, family planning, in vitro fertilization, and sterilization services** | | | |
| **Routine obstetrical (maternity) care[2]** | | | |
| • Routine prenatal visits | No charge | 20% of the MAC* | 20% of the MAC* |
| • Routine postpartum visit | No charge | | |
| • Delivery/hospital stay (uncomplicated) | No charge | | |
| **Non-routine obstetrical (maternity) care,** including complications of pregnancy and false labor | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |
| **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) | 20% of the MAC* | 20% of the MAC* |
| **Interrupted pregnancy[2]** | $15 per visit per office visit and $15 per visit in the ASC or other hospital-based setting | 20% of the MAC* | 20% of the MAC* |
| **Family planning office visits for female members** that are provided in accordance with the Patient Protection and Affordable Care Act | No charge | Not applicable–see the Preventive Care section in the KPIC Certificate of Insurance | Not applicable–see the Preventive Care section in the KPIC Certificate of Insurance |
| **All other family planning office visits** | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| **[1]In vitro fertilization (IVF)[2]**<br>- Limited to one-time only benefit while a Kaiser Permanente/KPIC member | 20% of applicable charges | 20% of the MAC*. Excluded for members or member's spouse who have had voluntary surgically-induced sterility (with or without reversal). | 20% of the MAC*. Excluded for members or member's spouse who have had voluntary surgically-induced sterility (with or without reversal). |
| **Sterilization services**<br>• Vasectomy services<br>• Female sterilizations[2], such as tubal ligation | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits<br>See also benefit exclusions and limitations lists. | In-network<br>Kaiser Permanente | Out-of-network †<br>Kaiser Permanente Insurance Company<br>Contracted Provider | <br><br>Non-contracted provider |
|---|---|---|---|
| | Member pays | Member pays | |
| **Reconstructive surgery** | | | |
| **Surgery to improve physical function,** such as surgery to correct congenital defects and birth anomalies<br>**Surgery following injury or medically necessary surgery**<br>**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†† | 20% of the MAC* | 20% of the MAC* |
| **Home health care and hospice care** | | | |
| **Home health care,** nurse and home health aide visits to homebound members, when prescribed by a physician | No charge (office visit copays apply to physician visits) | 20% of the MAC* limited to a combined maximum of 150 visits per calendar year. | 20% of the MAC* limited to a combined maximum of 150 visits per calendar year. |
| **Hospice care[2]** | No charge (office visit copays apply to physician visits)<br>Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. | 20% of the MAC* limited to a combined maximum of 210 days while insured. | 20% of the MAC* limited to a combined maximum of 210 days while insured. |
| **Skilled nursing care** | | | |
| **[1]Skilled nursing care services in an approved facility[2]** | No charge up to 120 days a year | 20% of the MAC* limited to a combined maximum of 120 days per calendar year. | 20% of the MAC* limited to a combined maximum of 120 days per calendar year. |

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits | In-network | Out-of-network † Kaiser Permanente Insurance Company | |
|---|---|---|---|
| See also benefit exclusions and limitations lists. | Kaiser Permanente | Contracted Provider | Non-contracted provider |
| | Member pays | Member pays | |
| **Emergency services** (covered for initial emergency treatment only) | | | |
| Emergency medical services are covered by Kaiser Foundation Health Plan, Inc. (KFHP). Non-emergency medical services received in an emergency care setting that are not covered by KFHP may be eligible for coverage by Kaiser Permanente Insurance Company (KPIC). Emergency department surcharge fees are not covered by KPIC. | | | |
| **At a facility within and outside the Hawaii service area for covered Emergency Services**<br>*Note: The In-Network copayment for emergency services is waived if you are directly admitted as a hospital inpatient from the emergency department (the hospital copay will apply).* | $50 per visit within the service area, and $50 per visit outside the service area. | | |
| Continuing or follow-up treatment for Emergency Medical Conditions at a non-Kaiser Permanente practitioners is not covered in-Network. | | | |
| **Urgent care services** | | | |
| **Urgent care services[2]** | | | |
| • At a Kaiser Permanente (or Kaiser Permanente -designated) urgent care center within the Hawaii service area, for primary care services | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| • At a Kaiser Permanente(or Kaiser Permanente -designated) urgent care center within the Hawaii service area, with a specialist | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| • At a non-Kaiser Permanente facility outside the Hawaii service area‡ | 20% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| ‡Urgent care is covered by Kaiser Foundation Health Plan, Inc. (KFHP). **"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 from non-Kaiser Permanente practitioners is not covered (in-network) by KFHP. Urgent care is only eligible for coverage by KPIC if the care received is not covered by KFHP as an In-Network benefit. | | | |
| **Ambulance services** | | | |
| **Ambulance services[2]** | 20% of applicable charges | 20% of the MAC* for scheduled transportation to or from an acute care hospital or skilled nursing facility where treatment is being rendered. Air ambulance will only be covered when medically necessary for the purpose of transporting the Member for receipt of acute care, and the Member's condition requires the services of an air ambulance for safe transport. | |

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits<br>See also benefit exclusions and limitations lists. | In-network<br>Kaiser Permanente | Out-of-network †<br>Kaiser Permanente Insurance Company<br>Contracted Provider | <br>Non-contracted provider |
|---|---|---|---|
| | Member pays | Member pays | |
| **Blood** | | | |
| **Blood and blood processing**[2] | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |
| **Mental health services**[2] | | | |
| **Mental health** outpatient services including office visits, day treatment and partial hospitalization services | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| **Mental health** hospital inpatient care including non-hospital residential services | $50 per day | 20% of the MAC* | 20% of the MAC* |
| **Chemical dependency services**[2]**/Substance abuse** | | | |
| Outpatient services, including office visits, day treatment and partial hospitalization services | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| Hospital inpatient care including non-hospital residential services and detoxification services | $50 per day | 20% of the MAC* | 20% of the MAC* |
| **Health education** | | | |
| Diabetes self-management training and education | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| General **health education services**[2] | $15 per visit | 20% of the MAC* | 20% of the MAC* |
| **Prescription drug coverage outside the service area** | | | |
| When outside of the Kaiser Permanente's service areas, up to 10 prescriptions of self-administered drugs | 20% of applicable charges | Not Covered | Not Covered |
| **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†† | 20% of the MAC* | 20% of the MAC* |
| **Durable medical equipment**[2] | | | |
| **Diabetes equipment** | 50% of applicable charges | 20% of the MAC* | 20% of the MAC* |
| **Home phototherapy equipment** for newborns | No charge | 20% of the MAC* | 20% of the MAC* |
| **Breast feeding pump,** including any equipment that is required for pump functionality | No charge | 20% of the MAC* | 20% of the MAC* |
| All other eligible **durable medical equipment** | 20% of applicable charges | 20% of the MAC* | 20% of the MAC* |

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

| Benefits | In-network | Out-of-network † Kaiser Permanente Insurance Company | |
|---|---|---|---|
| See also benefit exclusions and limitations lists. | Kaiser Permanente | Contracted Provider | Non-contracted provider |
| | Member pays | Member pays | |
| **External prosthetic devices and braces[2]** | | | |
| **External prosthetic devices and braces[2]**<br>A prosthetic device following mastectomy, if all or part of a breast is surgically removed for medically necessary reasons.<br>*Note: Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.* | 20% of applicable charges<br>Applicable internal prosthetics, devices, and aids cost shares apply | 20% of the MAC*<br>20% of MAC*, coverage limited to prosthetic devices following a mastectomy. | 20% of the MAC*<br>20% of MAC*, coverage limited to prosthetic devices following a mastectomy. |
| **Hearing aids,** provided once every 36 months for each hearing impaired ear | 60% of applicable charges | Not Covered | Not Covered |
| **Other medical services and supplies** | | | |
| **Anesthesia and hospital services for dental procedures for children with serious mental, physical, or behavioral problems** | Applicable cost shares apply. See applicable benefit sections†† | Not Covered | Not Covered |
| **Pulmonary rehabilitation** | Applicable cost shares apply. See applicable benefit sections†† | Not Covered | Not Covered |
| **Hyperbaric oxygen therapy** | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |
| **Anesthesia services,** including general anesthesia, regional anesthesia, and monitored anesthesia for high-risk members | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |
| **Orthodontic services for treatment of orofacial anomalies** resulting from birth defects or birth defect syndromes[2] | Applicable cost shares apply. See applicable benefit sections†† | 20% of the MAC* | 20% of the MAC* |
| **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.

1 See **Coverage Exclusions for in-Network Services** section

2 See **Coverage Limitations for in-Network Services** section

* Out-of-network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

** Members must pay their office visit copay for the office visit

† Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage.

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

## 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 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 lood 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 temporomandibular joint dysfunction (TMJ) or 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.
- 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 practitioner's 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 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.
- **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 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 the customer service center. 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 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 a 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 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 non8209;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.
- The **prescription drug coverage outside the service area** benefit is 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 member 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 prescription drug coverage outside the service area benefit cannot be combined with any other benefit, 4) Kaiser Permanente will not pay under this prescription drug coverage outside the service area 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 prescription drug coverage outside the service area benefit does not apply to Senior Advantage members and Medicare members with Medicare as primary coverage. The following are excluded under the prescription drug coverage outside the service area benefit: 1) transplant services and related care, 2) services received outside the United States, 3) services other than 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 prescription drug coverage outside the service area benefit.

- **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) per Benefit Period 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.
- 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, 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), prescription drug coverage outside the service area, 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 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 non8209;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 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.

- **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.

## Additional exclusions and limitations for out-of-network Services

When a service is excluded, all services that are necessary or related to the excluded service are excluded. "Service" includes any treatment, therapeutic or diagnostic procedure, drug, facility, equipment or device. No payment will be made under any benefit of the Group Policy for Expenses Incurred for or in connection with the following, unless specifically stated otherwise in the Group Policy.

Medical social services. This does not include those related to discharge planning in connection with: a) a covered Hospital Confinement; b) a covered Home Health Agency; or c) covered Hospice Care. Charges paid or payable by Health Plan. Charges in excess of the Maximum Allowable Charge. Weekend admission charges for non-Emergency Care services. This applies only to Friday through Sunday inclusive. Charges incurred for ambulance, emergency or urgent care that is covered by Health Plan. Confinement, treatment, services or supplies not Medically Necessary. This does not apply to preventive or other health care services specifically covered under the Group Policy that are not required to preserve the health of the Member. Confinement, treatment, services or supplies not recommended and approved by a Physician. Confinement, treatment, services or supplies received while not under the care and treatment of a Physician or other provider. Treatment which is not available in the United States. Charges for Injury or Sickness for which the Member is entitled to payment under any workers' compensation or similar law. Injury or Sickness for which the law requires the Member to maintain alternative insurance, bonding, or third party coverage. Injury or Sickness arising out of or in the course of past or current work for pay, profit, or gain, unless workers. compensation or benefits under similar law are not required or available. Injury or Sickness contracted while on duty with any military, naval, or air force of any country or international organization. Treatment of infertility except as specified in the Benefits section. Treatment, services, or supplies provided by the Insured Employee; his or her spouse; a child, sibling, or parent of the Insured Employee or of the Insured Employee's spouse; or a person who resides in the patient's home. Confinement, treatment, services or supplies received where care is provided at government expense. This does not apply if: a) there is a legal obligation for the Member to pay for such treatment or service in the absence of coverage; or b) payment is required by law. Dental care and dental x-rays, including but not limited to: dental services following accidental Injury to teeth; dental implants; dental appliances; orthodontia; and dental services associated with medical treatment, including surgery on the jawbone and radiation therapy, except as otherwise required to provide Orthodontic Services. Cosmetic services plastic surgery or other services that: a) are indicated primarily to improve the Member's appearance; and b) will not result in significant improvement in physical function. This does not apply to services that: a) will correct significant disfigurement resulting from a non-congenital Injury or surgery; or b) are incidental to a covered mastectomy. Orthotic devices, except as specifically set forth as a Covered Service. Gender reassignment. Sterilization reversals. Nonprescription drugs or medicines, vitamins, nutrients and food supplements–even if prescribed or administered by a Physician. Treatments, procedures, drugs or medicines which KPIC determines are experimental or investigational. This means that one or more of the following is true: a) the device, drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished, b) reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase, I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard of treatment or diagnosis, c) eligible evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, its efficacy, or its efficacy as compared with the standard of treatment or diagnosis. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine. Special education and related counseling or therapy; or care for learning deficiencies or behavioral problems. This applies whether or not associated with manifest mental illness or other disturbances. Services or supplies rendered for treatment of obesity or for weight reduction. This includes any surgical procedures or reversal thereof. Treatment of craniomandibular and

temporomandibular joint disorders. Confinement, treatment, services or supplies that are required; a) only by a court of law; or b) only for insurance, travel, employment, camp, government licensing, or similar purposes. Personal comfort items such as telephone, radio, television, or barber services. Custodial care. Custodial care is a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse. Care in an intermediate care facility. This is care for which a Physician determines the facilities and services of an acute care general Hospital or the Extended Care services of a Skilled Nursing Facility are not Medically Necessary. Routine foot care such as trimming of corns and calluses; or treatment of flat feet or partial dislocations in the feet. Confinement or treatment that is not completed in accordance with the attending Physician's orders, beginning on the date the orders are not followed. Confinement or treatment in accordance with the attending Physician's orders will be considered to be an eligible expense through the day prior to the date the orders are no longer being followed. Hearing therapy; or hearing aids. Private duty nursing. Acupuncture. Alternative medical services not accepted by standard allopathic medical practices including but not limited to hypnotherapy, behavior testing, sleep therapy, massage therapy, naturopathy, rest cure, aroma therapy, biofeedback or hypnotherapy. Health education, including but is not limited to: a) stress reduction; b) smoking cessation; c) weight reduction; or d) the services of a dietitian. Living expenses or transportation except as provided under Covered Services. Eye exams for contact lenses for the correction of vision. Radial keratotomies or photo refractive keratotomies. Long term rehabilitation and maintenance therapies. Any state or local sales tax. Prosthetics, drugs, injectables or equipment related to the treatment of sexual dysfunction. Manual manipulation of the spine unless specifically covered under a separate Rider attached to the Group Policy. Outpatient drugs and medicines, other than chemotherapy, unless otherwise stated in this Certificate or specifically covered under a separate Rider attached to the Group Policy. External prosthetics and braces, except as specifically set forth in this Certificate or covered under a separate Rider attached to the Group Policy. Eye glasses and contact lenses and their fitting, unless specifically covered under a separate Rider attached to the Group Policy. Convenience and luxury items. Experimental or research devices and appliances. The cost of equipment and the collection, storage, and processing of sperm for artificial insemination or in-vitro fertilization. In vitro fertilization for Members who have had voluntary surgically induced sterility. Conception by artificial means, other than artificial insemination and in-vitro fertilization, including but not limited to: ovum transplants; gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT). Cardiac rehabilitation programs. Transplants, including acquisition and/or donor costs. Take home supplies, including but not limited to disposable supplies such as bandages, gauze, tape, and antiseptics.

## 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.

| **Drug rider**<br>**4-Tier Prescription drug $3/$15/$50/$200 with 80%/20% out-of-network plan** | **In-network** | **Out-of-network †**<br>**Kaiser Permanente Insurance Company** | |
|---|---|---|---|
| | **Kaiser Permanente or designated pharmacy** | **Contracted pharmacy** | **Non-contracted pharmacy** |
| **Benefits** | **You pay** | **You pay** | |
| For each prescription | $3 per generic Maintenance drugs, $15 per prescription for all other generic drugs, $50 per brand-name drug prescription, $200 for specialty drugs, of a self-administered drug on the Health Plan formulary and used in accordance with formulary guidelines or restrictions. | 20% of charge, but not less than $3 per generic Maintenance drugs, $15 per prescription for all other generic drugs, $50 per brand-name drug prescription, $200 for specialty drugs (Limited to a 30-day supply per prescription) | Not covered |
| For in-network benefit only:<br>Each prescription does not exceed:<br>• a 30-consecutive-day supply of a prescribed drug, or<br>• an amount as determined by the formulary.<br><br>**Self-administered drugs** including drugs for the treatment of cancer, are provided in accordance with state and federal law and are covered only when all of the following criteria are met:<br>• prescribed by a physician/licensed prescriber, or a prescriber we designate,<br>• the drug is one for which a prescription is required by law, and<br>• drug does not require administration by nor observation by medical personnel. | | See Outpatient Prescription Drugs below | See Outpatient Prescription Drugs below |
| For Out-of-Network benefit only:<br>Each prescription does not exceed:<br>• a 30-consecutive-day supply of a prescribed drug, or<br>• an amount as determined by the KPIC formulary.<br><br>**Outpatient Prescription Drugs,** including drugs for the treatment of cancer, are provided in accordance with state and federal law and are covered only when all of the following criteria are met:<br>• prescribed by a physician/licensed prescriber , or a prescriber we designate,<br>• the drug is one for which a prescription is required by law, and<br>• the prescription is filled at a designated pharmacy | See Self-Administered Drugs above | | Not covered |

| | | | |
|---|---|---|---|
| **Insulin** | $3 per generic Maintenance drugs, $15 per prescription for all other generic drugs, $50 per brand-name drug prescription, $200 for specialty drugs, of a self-administered drug on the Health Plan formulary and used in accordance with formulary guidelines or restrictions. | 20% of charge, but not less than $3 per generic Maintenance drugs, $15 per prescription for all other generic drugs, $50 per brand-name drug prescription, $200 for specialty drugs (Limited to a 30-day supply per prescription) | Not covered |

**Diabetes supplies** (see the prescribed drugs section)

**Exclusions for in-network services:**

- Drugs which are obtained at pharmacies outside the Hawaii service area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc. or pharmacies we designate.
- Drugs for which a prescription is not required by law (e.g. over-the-counter drugs) including condoms, contraceptive foams and creams or other non-prescription substances used individually or in conjunction with any other prescribed drug or device. This exclusion does not apply to tobacco cessation drugs and products as described in the prescribed drugs section.
- Drugs in the same therapeutic category as the non-prescription drug, as approved by the Pharmacy & Therapeutics Committee
- Nonprescription 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.
- Name-brand drugs requested by a member when there is a generic equivalent.
- Prescribed drugs that are necessary for or associated with excluded or non-covered services.
- Drugs 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.

**Exclusions for out-of-network services:**

In addition to the exclusions of the Policy/Certificate, the following additional exclusions apply to the drug rider. Benefits will not be payable for:

- Prescriptions filled by pharmacies other than Added Choice Contracted Pharmacies.
- Drugs and medicines for which a prescription is not required by law, except those listed in the Formulary.
- Drugs and their associated dosage strengths and forms in the same therapeutic category as a non-prescription drug that have the same indication as the non-prescription drug. Prescribed drugs that are necessary for or associated with services excluded or not covered under the Policy/Certificate.

- Drugs not included on the KPIC formulary, unless a non-formulary drug has been specifically prescribed and authorized by the licensed Physician.
- Drugs to shorten the duration of the common cold.

---

### Questions and answers about the drug rider

1. ***How does the drug rider work?***
   When you visit a Kaiser Permanente or non-Kaiser Permanente physician, licensed prescriber, or prescriber we designate, and they prescribe a drug for which a prescription is required by law, you can take the prescription to either a Kaiser Permanente pharmacy, Kaiser Permanente-designated pharmacy, or Added Choice Participating Pharmacy.
   - If you go to a Kaiser Permanente or Kaiser Permanente-designated pharmacy, in most cases you will be charged only $3 per generic Maintenance drug prescription, $15 per prescription for all other generic drug prescriptions, $50 per brand-name drug prescription, and $200 per specialty drug prescription, which is on the Formulary, 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.
   - If you fill a prescription at an Added Choice Participating Pharmacy, you will be charged coinsurance equal to 20% of the charge, but not less than $3 per generic Maintenance drug prescription, $15 per prescription for all other generic drug prescriptions, $50 per brand-name drug prescription, and $200 per specialty drug prescription. Each refill of the same prescription will also be provided at the same coinsurance.
   - If you go to other pharmacies, you will be responsible for 100% of charge.

- ***Where are Kaiser Permanente pharmacies, Kaiser Permanente-designated pharmacies and Added Choice Participating Pharmacies located?***
  .Most Kaiser Permanente Clinics have a pharmacy on premises. Please consult the Added Choice Member Handbook and Provider Locations for the Kaiser Permanente-designated pharmacy and Added Choice Participating Pharmacy nearest you and its hours of operation.
- ***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 because these benefits vary depending on which plan you.ve selected. Even though nonformulary drugs are generally not covered under your prescription drug rider, your physician may 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, Kaiser Permanente-designated pharmacies, and Added Choice Participating Pharmacies may substitute a chemical or generic equivalent for a brand-name drug unless prohibited by your physician.

  Under the in-network benefit at a Kaiser Permanente or Kaiser Permanente-designated pharmacy, 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 Kaiser Permanente 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.

  Under the out-of-network coverage, if a member requests a brand form of the prescribed drug or authorized drug, the member must pay any difference in price between the generic equivalent drug prescribed or authorized by the physician and the requested brand.
- ***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 Member Services at 1-800-966 5955.
- ***What if I need more than a month's supply of medication?***
  Your Kaiser Permanente membership contract entitles you to a maximum one-month 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). Kaiser Permanente-designated pharmacies and Added Choice Participating Pharmacies will dispense only up to one month's supply. 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 for 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. Unless otherwise directed by Kaiser Permanente, refills may be allowed when 75% of the current prescription supply is taken/administered according to prescriber's directions.
- ***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 (808) 643-7979, press 1
- Order using our mail-order envelope, available at all Kaiser Permanente clinic locations.
- Order via our Pharmacy Refill Center at (808) 643-7979, press 3 then press 5, 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.

- ***What are the definitions of the different classes of drugs?***

  - **Generic drugs** are drugs approved by the U.S. Food and Drug Administration (FDA), have the same active ingredient of the Brand-name drugs, are produced and sold under their Generic names after the patent of the Brand-name drug expires, and are on the Health Plan formulary.
  - **Maintenance drugs** are those which are used to treat chronic conditions, such as asthma, hypertension, diabetes, hyperlipidemia, cardiovascular disease, and mental health, and are on the Health Plan formulary.
  - **Generic Maintenance drugs** are specific Generic drugs used for the treatment of chronic conditions and are on Health Plan.s approved list. However, not all Generic drugs used for the treatment of chronic conditions are considered Generic "Maintenance" drugs.
  - **Brand-name drugs** are drugs approved by the U.S. Food and Drug Administration (FDA), produced and sold under the original manufacturer.s Brand-name, and are on the Health Plan formulary. Brand-name drugs include single source drugs (where there is only one approved product available for that active ingredient, dosage form, route of administration, and strength).
  - **Specialty drugs** are very high-cost drugs approved by the U.S. Food and Drug Administration (FDA) that are on the Health Plan formulary.

| | Benefits | You pay |
|---|---|---|
| **Alternative medicine rider D - 20 visits / $20** | **Chiropractic, acupuncture and massage therapy services**<br>**Up to a combined maximum of 20 office visits per calendar year.**<br>**This rider does not cover services which are performed or prescribed by a Kaiser Permanente physician or other Kaiser Permanente health care provider.**<br>Services must be performed and received from Participating Chiropractors, Participating Acupuncturists, and Participating Massage Therapists of **American Specialty Health (ASH)**. Covered Services include:<br>• **Chiropractic services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders which are authorized by ASH and performed by a Participating Chiropractor.<br>• **Acupuncture services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea or Pain Syndromes which are authorized by ASH and performed by a Participating Acupuncturist.<br>• **Massage therapy services** for the treatment and diagnosis of myofascial/musculoskeletal pain syndromes which are referred by a Participating Chiropractor or Kaiser Permanente Physician, authorized by ASH and performed by a Participating Massage Therapist.<br>• **Adjunctive therapy** as set forth in a treatment plan approved by ASH, may involve chiropractic modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation; acupuncture therapies such as acupressure, moxibustion, and cupping; and other therapies.<br>• **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 Participating Chiropractor or staff member or referred to a facility that has been credentialed to meet the criteria of ASH. Diagnostic tests must be performed or ordered by a Participating Chiropractor and authorized by ASH. | $20 copayment per office visit |
| | **Chiropractic appliances** when prescribed and provided by a Participating Chiropractor and authorized by ASHN.<br>**Exclusions:**<br>• Any Chiropractic service or treatment not furnished by a Participating Chiropractor and not provided in the Participating Chiropractor's office.<br>• Any Acupuncture service or treatment not furnished by a Participating Acupuncturist and not provided in the Participating Acupuncturist's office.<br>• Any Massage Therapy service or treatment not furnished by a Participating Massage Therapist.<br>• Any massage services rendered by a provider of massage therapy services that are not delivered in accordance with the massage benefit plan and payor summary, including but not limited to limited massage services rendered directly in conjunction with chiropractic or acupuncture services.<br>• Examination and/or treatment of conditions other than Neuromusculo-skeletal Disorders from Participating Chiropractors; Neuromusculo-skeletal Disorders, Nausea, or Pain Syndromes from Participating Acupuncturists; or myofascial/musculoskeletal disorders, musculoskeletal functional disorders, Pain Syndromes, or lymphedema from Participating Massage Therapists.<br>• Services, lab tests, x-rays and other treatments not documented as medically necessary or as appropriate. | Payable up to a maximum of $50 per calendar year |

| | Benefits | You pay |
|---|---|---|

- 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, hypnotherapy, behavior training, sleep therapy, weight programs, 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 an acupuncturist, health food store, grocery store or by any other means.
- Prescriptive and non prescriptive drugs, injectables and medications.
- Transportation costs, such as ambulance charges.
- Hospitalization, manipulation under anesthesia, anesthesia or other related services.
- Diagnostic tests, laboratory services and tests for Acupuncture and Massage Therapy.
- 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, acupuncturist or massage therapist 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 acupuncture or chiropractic services.
- Services and/or treatment which are not documented as Medically Necessary services.
- Any services or treatment not authorized by ASH, except for an initial examination.
- Any office visits beyond 20 per calendar year.

**What you need to know about your alternative medicine benefits**

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

(b) **When are massage therapy services covered under this Rider?**
Massage Therapy Services for muscular and soft tissue disorders are referred by a Participating Chiropractor or Kaiser Permanente Physician, authorized by ASH and performed by a Participating Massage Therapist.

(c) **How do I choose a Participating Chiropractor, Participating Acupuncturist or Participating Massage Therapist?**
You may select a Participating Chiropractor, Participating Acupuncturist or Participating Massage Therapist that participates with ASH. You may obtain a list with their addresses and phone numbers by calling the Kaiser Permanente Customer Service Center at 1-800-966-5955. You may also view the list by logging on to our website at www.kp.org.

(d) **How do I obtain chiropractic or acupuncture services in Hawaii?**
Simply select a Participating Chiropractor or Participating Acupuncturist and call to set-up an appointment. At your appointment, present your Kaiser Permanente membership ID card and pay your designated copayment.

(e) **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 ASH are covered. The X-rays must be performed in either a Participating Chiropractor's office or an ASH ancillary provider's office in order to be covered.

**Kaiser Permanente Fit Rewards® Program provides these extra services**

| | | |
|---|---|---|
| **Kaiser Permanente Fit Rewards– Calendar Year** | **Basic Program fitness club and exercise center membership program**<br>• Eligible members may enroll with and American Specialty Health, Inc. (ASH) contracted network fitness club<br>• Program enrollment includes standard fitness club services and features<br>• Eligible Members should verify services and features with ASH contracted fitness club<br><br>**Note:**<br>• Eligible members must pay the Fit Rewards $200 annual program fee✦<br>• Eligible members must meet the 45-day, 30-minute per session activity requirement by end of 2017 | **No charge** |
| | **Or** | |
| | **Home Fitness Program**<br>• Eligible Members may select up to two of the available ASH home fitness kits per year | **$10** |
| | **Active&Fit website**<br>• 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.<br><br>The following are excluded from Active&Fit Program:<br>• Personal trainers, classes, and club services, amenities, and products or supplies that are not routinely included in the general membership<br>• Access to fitness or exercise clubs that are not part of ASH's contracted network.<br>• Home fitness kits not provided through ASH's Active&Fit program.<br>• Enrollment for Members not specifically listed as eligible for this program, as defined by the Group.<br>• 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

6314MEM-16 I KAH2707 I SEPTEMBER 2016

# 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**.



Active&Fit®

KAISER PERMANENTE® thrive