KAISER PERMANENTE®	CITY OF SAN JOSE RETIREES 34631

2010 Features of your Kaiser Permanente group plan

Benefit	Member Pays
Deductible	None
Lifetime maximum	None
Annual supplemental charges maximum per calendar year	$1,500 / $4,500
Preventive services	
Well-child office visits	No charge
Routine immunizations	No charge
One Preventive care office visit per calendar year (age 2 and older)	No charge
One gynecological office visit per calendar year (for female members)	No charge
Outpatient services	
Office visits	$5 per visit
Surgery and procedures	$5 per visit
Routine obstetrical (maternity) care	No charge
FDA-approved contraceptive drugs and devices	50% of applicable charges
Inpatient services	
Hospital room and board, doctors' medical and surgical services, and anesthesia services	No charge
Laboratory, imaging, and testing services	
Inpatient lab, imaging, and testing	No charge
Outpatient lab, imaging, and testing	$15 copay per department per day
Mental health services	
Outpatient office visits	$5 per visit
Hospital inpatient care	No charge
Day treatment or partial hospitalization services	$5 per visit
Non-hospital residential services	No charge
Chemical dependency services	
Outpatient office visits	$5 per visit
Hospital inpatient care	No charge
Day treatment or partial hospitalization services	$5 per visit
Non-hospital residential services	No charge
Emergency services (for initial treatment only)	
Within the Hawaii service area	$25 per visit
Outside the Hawaii service area	$25 per visit
Ambulance services	No charge
Corrective aids and appliances	
External prosthesis / durable medical equipment (with hearing aid $500 allowance)	No charge
All care and services must be coordinated by a Kaiser Permanente physician.	
Additional services	
Prescription drug 5	$5 per prescription
Prescription drug mail-order incentive	Two drug copayments for a 90-consecutive-day supply
Optical 1	No charge for lenses; frames (amounts over $40) OR contacts (amounts over $45); professional fees (amounts over $70)

This is only a summary. It does not fully describe your benefit coverage. For more details on your benefit coverage, exclusions, limitations, and plan terms, or for information, please refer to the attached, detailed benefit summary, to your employer, to *Our physicians and locations* directory for practitioner and provider availability, and to your *Member handbook*. This document is meant to be reviewed in conjunction with the attached, detailed benefit summary.

Kaiser Permanente Group Plan
2010 Benefits summary

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

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

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

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

Section	Benefits	You pay
Outpatient Services	**Primary care and specialty care office visits**(office visits are limited to one or more of the following services: exam, history, medical decision making)	$5 per visit
	Outpatient surgery and procedures	$5 per visit
	Preventative care office visits for:	
	• Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months)	No charge
	• One Preventive care office visit per calendar year (for members 2 years of age and over)	No charge
	• One gynecological office visit per calendar year for female members	No charge
	• Eye examinations for eyeglasses *	$5 per visit
	• Ear examinations to determine the need for hearing correction	$5 per visit
	Routine immunizations [1]	
	• For children 18 years of age and under on the date the immunization is administered [2]	No charge
	• For adults 19 years of age and over on the date the immunization is administered	No charge
	Influenza and pneumococcal immunizations [1]	No charge
	Unexpected mass immunizations [1]	50% of applicable charges
	[1] *Immunizations (routine, influenza, pneumococcal, and unexpected mass) for prevention of disease must meet all of the following criteria:* – *Recommended by the Advisory Committee on Immunization Practices (ACIP),* – *Published in the Morbidity and Mortality Weekly Report (MMWR) by the Centers for Disease Control and Prevention (CDC) in accordance with published criteria, guidelines, or restrictions, and* – *On the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions.* [2] *Includes routine immunizations (in keeping with "prevailing medical standards" as defined by state law) for children 5 years of age and under*	
	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)	$5 per visit
	Dialysis	
	• Kaiser Permanente physician and facility services for dialysis	10% of applicable charges
	• Equipment, training and medical supplies for home dialysis	No charge
	Materials for dressings and casts	No charge

▼ Members must pay their office visit copay for the office visit.
* See **Coverage Exclusions**
** See **Coverage Limitations**

Section	Benefits	You pay
Hospital inpatient care (for acute care registered bed patients)	**Hospital inpatient care** includes services such as: • Room and board • General nursing care and special duty nursing • Physicians' services • Surgical procedures • Respiratory therapy and radiation therapy • Anesthesia • Medical supplies • Use of operating and recovery rooms • Intensive care room	No charge
	Short-term physical, occupational and speech therapy ** (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply)	Included in the above hospital inpatient care copay
	Materials for dressings and casts	No charge
Laboratory, imaging, and testing services	**Inpatient laboratory services, imaging services, and testing services**	No charge
	Outpatient laboratory services, imaging services, and testing services	$15 copay per department per day
Transplants	**Transplants**, including kidney, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel, and small bowel-liver transplants *	See applicable benefit sections (e.g. - office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.)
Preventive screening services	**Preventive screening services** which meet Kaiser Permanente Prevention Committee's average risk guidelines are limited to the services listed below: • Anemia and lead screening for children • Colorectal cancer screening • Chlamydia detection • Fecal occult blood test • Lipid evaluation • Newborn metabolic screening • Cervical cancer screening • Screening mammography • Osteoporosis screening	No charge; member pays $5 for office visit if applicable
Prescribed drugs	**Prescribed drugs that require skilled administration by medical personnel** (e.g. cannot be self-administered) which meet all of the following: • Prescribed by a Kaiser Permanente licensed prescriber, • On the Health Plan formulary and used in accordance with formulary criteria, guidelines or restrictions, and • Prescription is required by law	No charge ▼
	Immunizations are described in the outpatient services section	
	Contraceptive drugs and devices are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section	
	Exclusions: • Self-administered drugs (such as drugs taken orally) • Drugs that are necessary or associated with services that are excluded or not covered	
	Your group may have purchased drug coverage for self-administered drugs under a separate rider. If so, it will be listed on the attached pages.	

▼ Members must pay their office visit copay for the office visit.
* See **Coverage Exclusions**
** See **Coverage Limitations**

Section	Benefits	You pay
Obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services	**Routine obstetrical (maternity) care** • Prenatal visits at the routine scheduled intervals, uncomplicated delivery/hospital stay, and routine post-partum visit *Note: If member is discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), the member's Kaiser Permanente physician may order a follow-up visit for the member and newborn to take place within 48 hours after discharge.*	No charge after confirmation of pregnancy (non-routine obstetrical care according to member's regular plan benefits)
	Inpatient stay and inpatient care for newborn during or after mother's hospital stay (assuming newborn is timely enrolled on Kaiser Permanente subscriber's plan)	Hospital inpatient care benefits apply (see hospital inpatient care section)
	Interrupted pregnancy	
	• Medically indicated abortions	$5 per visit
	• Elective abortions (including abortion drugs such as RU-486) limited to two per member per lifetime	$5 per visit
	Family planning office visits	$5 per visit
	FDA approved contraceptive drugs and devices ** (to prevent unwanted pregnancies)	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply) ▼
	Involuntary infertility office visits	$5 per visit
	Artificial insemination *	$5 per visit
	In vitro fertilization * • Limited to one-time only benefit at Kaiser Permanente • Limited to female members using spouse's sperm	20% of applicable charges
Home health care and hospice care	**Home health care**, nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	No charge
	Hospice care. Supportive and palliative care for a terminally ill member, as directed by a Kaiser Permanente physician. Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. The member must be certified by a Kaiser Permanente physician as terminally ill at the beginning of each period. (Hospice benefits apply in lieu of any other plan benefits for treatment of terminal illness.) Hospice includes services such as: • Nursing care (excluding private duty nursing) • Medical social services • Home health aide services • Medical supplies • Kaiser Permanente physician services • Counseling and coordination of bereavement services • Services of volunteers • Physical therapy, occupational therapy, or speech language pathology	No charge
Skilled nursing care rider - 100 days	Up to **100 days of prescribed skilled nursing care services in an approved facility** (such as a hospital or skilled nursing facility) **per benefit period**. Covered services include nursing care, room and board, medical social services, medical supplies, and durable medical equipment ordinarily provided by a skilled nursing facility. In addition to Health Plan criteria, Medicare guidelines are used to determine when skilled nursing services are covered, except that a prior three-day stay in an acute care hospital is not required. **Exclusions:** Personal comfort items, such as telephone, television and take-home medical supplies.	No charge

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

Section	Benefits	You pay
Emergency services ▲ (covered for initial emergency treatment only)	At a facility within the Hawaii service area for covered emergency services	$25 per visit
	At a facility outside the Hawaii service area for covered emergency services	$25 per visit
	Note: Member (or Member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility. ▲ *Emergency Services are those medically necessary services that meet the prudent layperson standard and were immediately required due to sudden and unforeseen illness/injury. In addition, in cases where care is received from non-Kaiser Permanente physicians, covered emergency services are only those where receipt of services from a Kaiser Permanente physician would have entailed a delay resulting in death, serious impairment to bodily functions, serious dysfunction of any bodily organ, or placing the health of the individual in serious jeopardy.* ***Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.***	
Out-of-area urgent care services (while temporarily outside the Hawaii service area)	At a non-Kaiser Permanente facility for covered urgent care services (Coverage for initial urgent care treatment only)❖ ❖ *"Urgent Care Services" means initial care for a sudden and unforeseen illness or injury when the member is TEMPORARILY away from the Hawaii service area, which is required to prevent serious deterioration of the member's health and which cannot be delayed until the member is medically able to safely return to the Hawaii service area or travel to a Kaiser Permanente facility in another Health Plan Region.* ***Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.***	20% of applicable charges
Ambulance services	Ambulance Services are those services in which: • Use of any other means of transport, regardless of availability of such other means, would result in death or serious impairment of the member's health, and • Is for the purpose of transporting the member to receive medically necessary acute care. In addition, air ambulance must be for the purpose of transporting the Member to the nearest medical facility designated by Health Plan for receipt of medically necessary acute care, and the member's condition must require the services of an air ambulance for safe transport.	No charge
Blood	Regardless of replacement, units and processing of units of **whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin**	No charge
	Collection, processing, and storage of autologous blood when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used	No charge
Mental health services	Outpatient office visits	$5 per visit
	Hospital inpatient care	No charge
	Specialized facility services Services in a specialized mental health treatment unit or facility approved by Kaiser Permanente Medical Group	
	• Day treatment or partial hospitalization services	$5 per visit
	• Non-hospital residential services	No charge
Chemical dependency services	Outpatient office visits	$5 per visit
	Hospital inpatient care	No charge
	Specialized facility services Services in a specialized alcohol or chemical dependence treatment unit or facility approved by Kaiser Permanente Medical Group	
	• Day treatment or partial hospitalization services	$5 per visit
	• Non-hospital residential services	No charge

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

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

Internal prosthetics are those which meet all of the following criteria:

- 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,
- Are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA),
- Were in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, and
- Are not excluded from coverage from Medicare, and if covered by Medicare, meet the coverage definitions, criteria and guidelines established by Medicare at the time the device is prescribed.

Exclusions:

- All implanted internal prosthetics and devices and internally implanted aids related to an excluded or non-covered service/benefit
- Prosthetics, devices, and aids related to sexual dysfunction

Limitations:

- 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.

Section	Benefits	You pay
Diabetes equipment	**Diabetes equipment** (limited to blood glucose monitors and external insulin pumps, and the supplies necessary to operate them) which are prescribed by a Kaiser Permanente physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan **Diabetes equipment** is that equipment and supplies necessary to operate the equipment which: • Is intended for repeated use, • Is primarily and customarily used to serve a medical purpose, • Is appropriate for use in the home, • Is generally not useful to a person in the absence of illness or injury, • Was in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, • Is not excluded from coverage from Medicare, and if covered by Medicare, meets the coverage definitions, criteria and guidelines established by Medicare at the time the diabetes equipment is prescribed, and • Is on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions. **Exclusions:** • Comfort and convenience equipment, and devices not medical in nature. • Disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages. • Repair, adjustment or replacement due to misuse or loss. • Experimental or research equipment. **Limitations:** • If rented or loaned from Health Plan, the Member must return any diabetes equipment items to Health Plan or its designee or pay Health Plan or its designee the fair market price for the equipment when it is no longer prescribed by a Physician or used by the Member. • Coverage is limited to the standard item of diabetes equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.	50% of applicable charges
Dependent coverage up to age 19	Unmarried dependent (biological, step or adopted) children of the Subscriber (or the Subscriber's spouse) are eligible up to the child's 19th birthday. Other unmarried dependents may include: • The Subscriber's (or Subscriber's spouse's) dependent (biological, step or adopted) children (over age 19) who are incapable of self-sustaining employment by reason of mental retardation or physical handicap, and are chiefly dependent upon the Subscriber (or Subscriber's spouse) for support and maintenance (proof of incapacity and dependency may be required). • A person who is under age 19, is living in a parent-child relationship with the Subscriber (or Subscriber's spouse) is entirely supported by the Subscriber (or Subscriber's spouse), is permanently living in the Subscriber's household, and for whom the Subscriber (or Subscriber's spouse), is (or was before the person's 18th birthday) the court appointed legal guardian.	
Student coverage up to age 25	Unmarried dependent (biological, step or adopted) children who are full-time students pursuing a license, degree or professional certification at a state recognized and duly accredited school or university and have the same legal address as the Subscriber are eligible up to the child's 25th birthday. To qualify for this coverage, the Subscriber must fill out a Student Certification Form for each eligible dependent and return it to Kaiser Permanente. This information is subject to prior verification by Kaiser Permanente.	

▼ Members must pay their office visit copay for the office visit.
* See **Coverage Exclusions**
** See **Coverage Limitations**

Section	Benefits	You pay
Supplemental charges maximum	**Your out-of-pocket expenses for covered Basic Health Services are capped each year by a supplemental charges maximum.** ***YOU MUST RETAIN YOUR RECEIPTS*** for these supplemental charges and when that maximum amount has been **PAID**, present these receipts to our Business Office at Moanalua Medical Center, Honolulu, Waipio, or Wailuku Clinics, or to the cashier at other clinics. After verification that the supplemental charges maximum has been **PAID, you will be given a card** which indicates that no additional supplemental charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to **show this card** at your visits to ensure no additional supplemental charges are billed or collected for the remainder of the calendar year in which the medical services were received. **All payments are credited toward the calendar year in which the medical services were received.** You will be provided an updated status about which of your payments may be applied to the supplemental charges maximum. Please allow a minimum of 10 working days to verify that your supplemental charge maximum has been met. Note: Once you have met the supplemental charges maximum, please submit your proof of payment as soon as reasonably possible. All receipts must be submitted no later than February 28 of the year following the one in which the medical services were received. **Supplemental charges for the following covered Basic Health Services** can be applied toward the supplemental charges maximum: ambulance service, artificial insemination, chemical dependency services (including residential services), dialysis, drugs requiring skilled administration, emergency service, family planning office visits, health evaluation office visits for adults, home health, imaging (including X-rays), immunizations (excluding travel immunizations), in vitro fertilization procedure (excluding drugs), infertility office visits, inpatient room (semi-private), interrupted pregnancy/abortion, laboratory, mental health services, obstetrical (maternity) care, covered office visits for services listed in this Basic Health Services section, outpatient surgery and procedures, radiation and respiratory therapy, reconstructive surgery, short-term physical therapy, short-term speech therapy, short-term occupational therapy, testing services, transplants (the procedure), and urgent care. These are not Basic Health Services and charges for these services/items are ***not*** applicable towards the supplemental charges maximum: all services for which coverage has been exhausted, all excluded or non-covered benefits, all other services not specifically listed above as a Basic Health Service, allergy test materials, blood or blood processing, braces, complementary alternative medicine (chiropractic, acupuncture, or massage therapy), contraceptive drugs and devices, dental services, diabetes supplies and equipment, dressings and casts, durable medical equipment, external prosthetics, handling fee or taxes, health education services, classes or support groups, hospice, internal prosthetics, internal devices and aids, medical foods, medical social services, office visits for services which are not Basic Health Services, orthopedic devices, radioactive materials, self administered/outpatient prescription drugs, skilled nursing care, take-home supplies, and travel immunizations.	$1,500 per member, $4,500 per family unit (3 or more members), for calendar year
Lifetime Maximum Unlimited	The lifetime maximum is the maximum benefit paid by Health Plan for covered Services for a member. Health Plan will pay the accumulated cost of most services while a member is enrolled under the same group plan and product with the unlimited Lifetime Maximum benefit	

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*** Coverage exclusions**

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

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

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

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* Coverage limitations

Benefits and Services are subject to the following limitations:

- Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.
- Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when Kaiser Permanente physicians believe no professionally acceptable alternative treatment exists. Coverage will cease at the point the member stops following the recommended treatment.
- Members are covered for **contraceptive drugs and devices** only when the prescription drugs meet all of the following criteria: 1) prescribed by a licensed Prescriber, 2) the drug is one for which a prescription is required by law, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc.
- **Internally implanted prosthetics, devices, and aids** (such as pacemakers, hip joints, surgical mesh, stents, bone cement, bolts, screws, and rods), **durable medical equipment** (if you have a Durable Medical Equipment Rider), and **external prosthetics and braces** (if you have an External Prosthetic Devices and Braces Rider) are subject to Medicare coverage guidelines and limitations.
- **Diabetes equipment** and supplies necessary to operate them are subject to Medicare coverage guidelines and limitations, must be preauthorized in writing by Kaiser Permanente, and obtained from a Health Plan designated vendor.
- Short-term **physical, occupational and speech therapy Services** means medical services provided for those conditions which meet all of the following criteria: a) the therapy is ordered by a Physician under an individual treatment plan; b) in the judgment of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy; c) the therapy is provided by or under the supervision of a Physician-designated licensed physical, speech, or occupational therapist, as appropriate.; and d) as determined by a Physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury.

Neurological and/or musculoskeletal function is sufficient when one of the following first occurs: i) neurological and/or musculoskeletal function is the level of the average healthy person of the same age, ii) further significant functional gain is unlikely, or iii) the frequency and duration of therapy for a specific medical condition as specified in Kaiser Permanente Hawaii's Clinical Practice Guidelines has been reached. **Occupational therapy** is limited to hand rehabilitation services, and medical services to achieve improved self care and other customary activities of daily living. **Speech-language pathology** is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin.

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

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

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

	Benefits	You pay
Durable medical equipment rider - $0	**Durable medical equipment**, including oxygen dispensing equipment (and oxygen), used during a covered stay in a Hospital or Skilled Nursing Facility	No Charge
	Medically necessary and appropriate **durable medical equipment for use in the home**, when prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan	No charge
	Oxygen for use in conjunction with prescribed durable medical equipment	No charge
	Repair, replacement and adjustment of durable medical equipment, other than those due to misuse or loss	No charge

Durable medical equipment is that equipment and related supplies which meet all of the following criteria:

- Is intended for repeated use,
- Is primarily and customarily used to serve a medical purpose,
- Is appropriate for use in the home,
- Is generally not useful to a person in the absence of illness or injury,
- Was in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, and
- Is not excluded from coverage from Medicare, and if covered by Medicare, meets the coverage definitions, criteria and guidelines established by Medicare at the time the durable medical equipment is prescribed.

Exclusions:

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

Limitations:

- If rented or loaned from Health Plan, the Member must return any durable medical equipment items to Health Plan or its designee or pay Health Plan or its designee the fair market price for the equipment when it is no longer prescribed by a Physician or used by the Member.
- Coverage is limited to the standard item of durable medical equipment in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.

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

Definitions:

External Prosthetic Devices are those which meet all of the following criteria:

- Are affixed to the body externally,
- Are required to replace all or part of any body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ,
- Were in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, and
- Are not excluded from coverage from Medicare, and if covered by Medicare, meet the coverage definitions, criteria and guidelines established by Medicare at the time the prosthetic is prescribed.

Braces are those rigid and semi-rigid devices which:

- Are required to support a weak or deformed body member, or
- Are required to restrict or eliminate motion in a diseased or injured part of the body, and
- Are not excluded from coverage from Medicare, and if covered by Medicare, meet the coverage definitions, criteria and guidelines established by Medicare at the time the brace is prescribed.

Exclusions:

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

Limitations:

- Coverage is limited to the standard model of external prosthetic device or brace in accord with Medicare guidelines that adequately meets the medical needs of the Member. Convenience and luxury items and features are not covered.

	Benefits	You pay
Hearing Aids rider - $500 allowance	Up to $500 allowance per calendar year for up to 2 hearing aid(s) every 36 months, when prescribed by a KP physician or KP audiologist, and obtained from sources designated by Health Plan	$500 less than regular cost

Exclusions:

- All other hearing aid related costs, including but not limited to: consultation, fitting, rechecks and adjustments for the hearing aid(s).
- All other costs greater than the $500 allowance given once every 36 months.

	Benefits	You pay
Drug rider 5	**For each prescription, when the quantity does not exceed:** • a 30-consecutive-day supply of a prescribed drug, or • an amount as determined by the formulary.	$5 per prescription
	Self-administered drugs are covered only when all of the following criteria are met: • prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate, • on the Kaiser Permanente Hawaii Drug Formulary. Senior Advantage members with Medicare Part D are entitled to drugs on the Kaiser Permanente Hawaii Drug Formulary and Kaiser Permanente Hawaii Medicare Drug Formulary. Drugs must be used in accordance with formulary criteria, guidelines, or restrictions, • the drug is one for which a prescription is required by law, • obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc., or pharmacies we designate, and • drug does not require administration by nor observation by medical personnel..	
	Insulin	$5 per prescription
	Contraceptive drugs and devices are described in the obstetrical care, interrupted pregnancy, family planning, involuntary infertility services, and artificial conception services section	

Exclusions:

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

Questions and answers about the drug rider

1. ***How does the drug rider work?***
When you visit a Kaiser Permanente physician, a licensed prescriber or a prescriber we designate, and they prescribe a drug for which a prescription is legally required, you can take it to any Kaiser Permanente pharmacy or pharmacy we designate.
    - In most cases you will be charged only $5 for a prescription when it does not exceed a 30-consecutive-day supply of a prescribed drug (or an amount as determined by the formulary). Each refill of the same prescription will also be provided at the same charge.
    - If you go to a non-Kaiser Permanente pharmacy, you will be responsible for 100% of charges.

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

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

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

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

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

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

    You can order your refills at your convenience, 24/7, using one of the methods below.
    - For the quickest turnaround time, order online at kp.org.
    - Order via our automated prescription refill service by calling 432-7979 (Oahu) or 1-888-867-2118 (Neighbor Islands). You'll have the following options:
        - To check your order status, press 1.
        - To order refills, press 2. You will be asked to enter your medical record number and prescription number. Then you'll have the option of receiving your refills via mail order (by pressing 1) or picking up your refills at one of our locations (by pressing 2)
        - To listen to detailed instructions, press 3.
    - Order using our mail-order envelope, available at all Kaiser Permanente clinic locations.
    - Order via our Pharmacy Refill Center at (808) 432-5510 (Oahu), or toll free 1-866-250-1805 (Neighbor Islands), Monday to Friday, 8:30 a.m. to 5 p.m. TTY users may call 1-877-447-5990.

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

    If you must pick up your prescriptions at a clinic pharmacy, refillable prescriptions are usually ready for pickup at the designated pharmacy in one business day. Prescriptions requiring a physician's approval are usually ready in two business days. Call the pharmacy or Kaiser Permanente Hawaii's automated prescription refill line in advance to make sure that your prescription is ready. Orders not picked

up within one week are returned to stock.

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

Your base health plan coverage provides:

Care in the Medical Office

- Routine eye examinations for eyeglasses
- Diagnosis, treatment and continued care for conditions related to disease or injuries of the eye by an eye specialist

Care in the Hospital

- Physicians and surgeons services
- Room and board, general nursing care, anesthesia, use of operating room and medications

Optical rider 1 provides these additional services and benefits

Optical rider 1	Benefits	You pay
	When prescription is filled at Kaiser Permanente Optical Center:	
	Glasses	
	• Once every 24 months and one pair of new lenses after 12 months	No charge❖
	• Eye examinations for glasses should be scheduled in advance(covered according to base plan)	Applicable office visit copay
	Or	
	Contact lenses (in lieu of glasses)	
	• If member chooses - one pair of contact lenses every 24 months*	$45 less than regular cost
	• Eye examinations for contact lenses and fitting services	Eye examinations for contact lenses are excluded, but the member will receive a $70 professional fee credit for required initial or refitting exam (to apply towards the contact lenses examination) if contact lenses are purchased at a Kaiser Permanente facility.
	Members may elect to order items not covered under this rider. The following items are available at additional charges: • Tints including photochromic, polarized or tinted plastic lenses • Special lens materials such as polycarbonate and high-index materials • Multi-focal styles such as progressive lenses • Contact lenses, not medically required • Frames over $40 • Sunglasses	

❖ Glasses are regular scratch resistant lenses (plastic single vision, flat top (28 mm), multi-focal or lenticular lenses having refractive values) placed in a frame costing $40 or less. For members who are 18 years of age and under, the lens material will be impact resistant polycarbonate.

* If a member chooses disposable contact lenses, member may purchase as many months supply as needed. However the member's covered benefit will be limited to $45 once every 24 months.