Kaiser Foundation Health Plan, Inc.

A NOT-FOR-PROFIT HEALTH PLAN – HAWAII MARKET

2024 Summary of Important Changes for Contract Renewals for the Kaiser Permanente Group Plans

(These changes are subject to regulatory approval)

The Evidence of Coverage (EOC) is the legally binding contract between Kaiser Foundation Health Plan and its members. The EOC includes the Kaiser Permanente Hawaii's Guide to your Health Plan, your employer's Group Agreement, riders, and amendments, if any. In the event of ambiguity, or a conflict between this summary and the EOC, the EOC shall control.

Please note that this summary does not fully describe your coverage. For details on your coverage, please refer to your *Kaiser Permanente Hawaii's Guide to Your Health Plan (Guide).* This summary does not apply to Added Choice out-of-network coverage, Kaiser Permanente for Individuals and Families, Federal, State, Quest Integration or Medicare members.

For specific questions about benefits, you may call our Member Services at 1-800-966-5955 (TTY 711).

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

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

CONTRACT CHANGES (that apply to all group plans)
These changes become effective on your employer's contract renewal date, unless specified otherwise below.

1. **Orthodontic Care for the Treatment of Orofacial Anomalies (from birth).** For orthodontic care for the treatment of orofacial anomalies (from birth), the state of Hawaii Insurance Commissioner will increase the maximum benefit per treatment phase to $6,898 per calendar year (was $5,500).

CONTRACT LANGUAGE CLARIFICATIONS (that apply to all group plans)
These clarifications are effective immediately, unless otherwise specified below.

1. **Rehabilitation Services.** Clarify that rehabilitation services (such as pulmonary and cardiac) are covered when preauthorized in writing by Kaiser Permanente.
2. **No Surprises Act.** Revise language to add Post-Stabilization Care furnished by a non-Plan Provider, Independent Freestanding Emergency Department and Ancillary Service.

PLAN-SPECIFIC COST SHARE CHANGES (that only apply to specifically below-named plans)
These changes become effective on your employer's contract renewal date, unless specified otherwise below.

KP Group

- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

KP Group $25 / $150 (20% LIT)

- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

KP Group $20 / 20% ($300)

- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit after deductible (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges after deductible (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges after deductible (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges after deductible (was not covered).

KP HI Platinum 0/15

- Outpatient basic labs and imaging will be $15 per day (was $10 per day).
- Hearing aids appliances will be 20% of Applicable Charges (was 60%).
- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

KP HI Platinum 0/20

- Hearing aids appliances will be 20% of Applicable Charges (was 60%).
- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

KP HI Platinum 0/20 Rx Ded

- Hearing aids appliances will be 20% of Applicable Charges (was 60%).
- Outpatient self-administered brand drugs will be covered at $75 per prescription (was $50).
- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

KP Platinum Added Choice (in-network) (formerly called KP Platinum Added Choice - $20)

- Hearing aids appliances will be 20% of Applicable Charges (was 60%).

KP HI Gold 300/20 - B

- Outpatient self-administered generic other drugs will be covered at $30 per prescription (was $30 after deductible).
- Dependent Child Coverage Outside the Service Area. Outpatient specialty care and primary care for the first 10 visits will be covered at $20 per visit (specialty care was not covered). Outpatient care after 10 visits will be covered at 50% of Applicable Charges (was not covered). Basic laboratory, general imaging, and testing services after combined limit of 10 visits will be covered at 50% of Applicable Charges (was not covered). Self-administered drugs after 10 prescriptions will be covered at 50% of Applicable Charges (was not covered).

Kaiser Foundation Health Plan, Inc.

Kaiser Permanente Hawaii's Guide to Your Health Plan

KP HI Platinum 0/20 Plan

JANUARY 2024

Benefit Summary

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- Chemotherapy
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- Medical Equipment and Supplies
- Behavioral Health - Mental Health and Substance Abuse
- Transplants
- Prescription Drugs
- Miscellaneous Medical Treatments

Benefit and Payment Chart

About this Chart

This benefit and payment chart:

- Is a summary of covered services and other benefits. It is not a complete description of your benefits. For coverage criteria, description and limitations of covered Services, and excluded Services, be sure to read *Chapter 1: Important Information*, *Chapter 3: Benefit Description*, and *Chapter 4: Services Not Covered.*
- Tells you if a covered service or supply is subject to limits or referrals.
- Gives you the page number where you can find the description of your services and other benefits.
- Tells you what your Cost Share is for covered services and supplies.

Note: Special limits may apply to services or other benefits listed in this benefit and payment chart. Please read the benefit description found on the page referenced by this chart.

You only pay a single Cost Share for covered benefits you receive in the Total Care Service settings. If your care is not received in a Total Care setting, you pay the Cost Share for each medical service or item in accord with its relevant benefit section.

If a benefit in the Benefit and Payment Chart is not listed, or is listed as "Not covered" the descriptions related to that benefit in Chapter 1, 3, and 4 are not applicable.

Remember, services and other benefits are available only for care you receive when provided, prescribed, or directed by your KP Hawaii Care Team except for care for Emergency Services and out-of-state Urgent Care. To find a Medical Office near you visit our website at www.kp.org. For more information on these services see *Chapter 3: Benefit Description.* You are encouraged to choose a Personal Care Physician (PCP). You may choose any PCP that is available to accept you. Parents may choose a pediatrician as the PCP for their child.

You do not need a referral or prior authorization to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. Your Physician, however, may have to get prior authorization for certain Services. Additionally, in accord with state law, you do not need a referral or prior authorization to obtain access to physical therapy from a physical therapist or Physician who specialized in physical therapy.

Members age 65 and over (excluding Tax Equity and Fiscal Responsibility Act of 1982 "TEFRA" members) must meet the required eligibility requirements to receive the benefit of either 1) those listed in this *Benefit Summary*, or 2) benefits covered under Original Medicare. See *Chapter 9: Coordination of Benefits*. Senior Advantage Members, please refer to your Senior Advantage Evidence of Coverage.

Description	Cost Share
Annual Copayment Maximum	
Member	$2,500 per calendar year
Family Unit	$5,000 per calendar year (for 2 or more members)
Annual Deductible	
Member	None
Family Unit	None
Routine and Preventive	
Health Education and Disease Management	
• Medical Office Visits	
○ Primary Care	$20 per visit
○ Specialty Care	$20 per visit
• Tobacco Cessation and Counseling Sessions	None
• Health education publications	None
• Healthy Living Classes	Applicable class fees
Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))	None
• Office Visit for (CDC) Immunizations	None
• Office visit for Travel Immunization	
○ Primary Care	$20 per visit
○ Specialty Care	$20 per visit
Medical Office Visits	
• Well-Child Care	None
• Annual Preventive Care (physical exam)	None
• Hearing Exam (for correction)	
○ Primary Care	$20 per visit
○ Specialty Care	$20 per visit
• Vision Exam (for glasses)	
○ Primary Care	$20 per visit
○ Specialty Care	$20 per visit
Preventive Screenings and Care	None
Total Health Assessment (www.kp.org)	None
Special Services for Women	
Preventive Care	
• Annual Gynecological Exam	None
• Mammography (screening)	None
• Pap Smears (cervical cancer screening)	None
Family Planning Visits	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
Infertility Consultation	
• Primary Care	$20 per visit

Description	Cost Share
• Specialty Care	$20 per visit
In Vitro Fertilization	20% of Applicable Charges
Maternity	
• Maternity Care – routine prenatal visits in Medical Office	None
• Maternity Care – delivery	20% of Applicable Charges
• Maternity Care – one postpartum visit in Medical Office	None
• Maternity and Newborn Inpatient Stay	20% of Applicable Charges
• Breast Pump	None
Pregnancy Termination	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
• Total Care Settings	Included in Total Care Services
Voluntary sterilization (including tubal ligation)	
• Medical Office	None
• Total Care Settings	None
Special Services for Men	
Vasectomy	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
• Total Care Settings	Included in Total Care Services
Online Care	
My Health Manager (www.kp.org)	None
Medical Office Visits	
Medical Office Visits	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
• Routine pre-surgical and post-surgical	None
Urgent Care Visits	
• Within Service Area	$20 per visit
• Outside Service Area	20% of Applicable Charges
Dependent Child Outside of Service Area	
• Outpatient Care	$20 per visit for the first 10 visits, and 50% of Applicable Charges for additional visits
• Basic laboratory and general imaging	$10 per visit for the first 10 visits (combined total for laboratory, imaging and testing), and 50% of Applicable Charges for additional visits
• Testing	20% of Applicable Charges for the first 10 visits (combined total for laboratory, imaging and testing), and 50% of Applicable Charges for additional visits
• Immunizations	None

Description	Cost Share
• Contraceptive drugs and devices	None
• Self-administered drug prescriptions	20% of Applicable Charges for the first 10 prescriptions, and 50% of Applicable Charges for additional prescriptions
House Calls	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
Telehealth	Cost Share, if applicable, will vary depending on Service
Laboratory, Imaging, and Testing	
Laboratory	
• Basic	$20 per day
• Specialty	20% of Applicable Charges
Imaging	
• General	$20 per day
• Specialty	20% of Applicable Charges
Testing	
• Allergy Testing	
○ Primary Care	$20 per visit
○ Specialty Care	$20 per visit
• Skilled-Administered Drugs	20% of Applicable Chares
• Diagnostic Testing	20% of Applicable Charges
Surgery	
Outpatient Surgery and Procedures	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
• Total Care Settings	Included in Total Care Services
Reconstructive Surgery	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
• Covered Mastectomy	20% of Applicable Charges
• Total Care Settings	Included in Total Care Services

Description	Cost Share
Total Care Services	
You may only pay a single Cost Share for covered benefits you receive in Total Care Service settings. Here are examples:	
Inpatient Hospital Services	20% of Applicable Charges
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	20% of Applicable Charges
Emergency Services	20% of Applicable Charges
Observation	20% of Applicable Charges
Skilled Nursing Facility	20% of Applicable Charges for up to 120 days per Accumulation Period
Dialysis	
• Dialysis	20% of Applicable Charges
• Equipment, Training and Medical Supplies for home Dialysis	None
Radiation Therapy	20% of Applicable Charges
Ambulance	
Air Ambulance	20% of Applicable Charges
Ground Ambulance	20% of Applicable Charges
Physical, Occupational, and Speech Therapy	
Physical and Occupational Therapy	
• Medical Office	$20 per visit
• Home Health Care	None
• Total Care Settings	Included in Total Care Services
Speech Therapy	
• Medical Office	$20 per visit
• Home Health Care	None
• Total Care Settings	Included in Total Care Services
Home Health Care and Hospice Care	
Home Health Care	None
Hospice Care	None
Physician Visits	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
Chemotherapy	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
• Total Care Settings	Included in Total Care Services

Description	Cost Share
Internal, External Prosthetics Devices and Braces	
Implanted Internal Prosthetics, Devices and Aids	
• Medical Office	None
• Total Care Settings	Included in Total Care Services
External Prosthetics Devices	
• Outpatient	10% of Applicable Charges
• Total Care Settings	Included in Total Care Services
Braces	
• Outpatient	10% of Applicable Charges
• Total Care Settings	Included in Total Care Services
Durable Medical Equipment	
Durable Medical Equipment	
• Outpatient	10% of Applicable Charges
• Total Care Settings	Included in Total Care Services
Oxygen (for use with DME)	
• Outpatient	10% of Applicable Charges
• Total Care Settings	Included in Total Care Services
Repair or Replacement	
• Outpatient	10% of Applicable Charges
• Total Care Settings	Included in Total Care Services
Diabetes Equipment	50% of Applicable Charges
Home Phototherapy Equipment	None
Behavioral Health – Mental Health and Substance Abuse	
Mental Health Care	
• Medical Office	$20 per visit
• Total Care Settings	Included in Total Care Services
Chemical Dependency Care	
• Medical Office	$20 per visit
• Total Care Settings	Included in Total Care Services
Autism Care	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
Transplants	
Transplant Care for Transplant Recipients	
• Primary Care	$20 per visit
• Specialty Care	$20 per visit
• Total Care Settings	Included in Total Care Services
Transplant Services for Transplant Donors (based on health plan approval)	

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

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

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Kaiser Foundation Health Plan, Inc. – Hawaii

ACA Small Group Amendment

This amendment is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this amendment.

For Senior Advantage members, this amendment is included in the Medical Benefits Chart in the front of the *Evidence of Coverage (EOC).*

Benefit Summary

Description	Cost Share
Physical, Occupational and Speech Therapy Habilitative Services	
• Medical Office	Same physical, occupational, and speech therapy Medical Office Cost Shares listed in the Benefit Summary in front of this Guide
• Home Health Care	Same home health care Cost Share listed in the Benefit Summary in front of this Guide
• Total Care Settings	Included in Total Care Services
Prescription Drugs Self-Administered Drugs in accord with USPSTF and PPACA	None
Special Services for Women Family Planning Visits in accord with PPACA	None
Behavioral Health – Mental Health and Substance Abuse Conditions listed in current DSM	Same behavioral health Cost Shares listed in the Benefit Summary in front of this Guide

Description	Cost Share
Emergency Services	
Emergency services from dentists	Same emergency services Cost Shares listed in the Benefit Summary in front of this Guide
Miscellaneous Medical Treatments	
Erectile Dysfunction	
• Primary Care	Same primary care Cost Share listed in the Benefit Summary in front of this Guide
• Specialty Care	Same specialty care Cost Share listed in the Benefit Summary in front of this Guide
• Total Care Settings	Included in Total Care Services
Temporomandibular Joint Dysfunction	
• Primary Care	Same primary care Cost Share listed in the Benefit Summary in front of this Guide
• Specialty Care	Same specialty care Cost Share listed in the Benefit Summary in front of this Guide
• Total Care Settings	Included in Total Care Services
Vision appliances and procedures	Cost Share will vary depending on service
Pediatric Vision Care	
• One eye exam	None
• One pair of eyeglasses (lenses and frame)	None
• One pair of non-disposable contact lenses (in lieu of eyeglasses)	None
• Medically necessary contact lens	None
• One low vision hand-held or page magnifier device	None
Pediatric Oral Care services are only covered under this Kaiser Permanente EOC if specifically provided by a separate dental rider bundled with this plan.	Not covered

Benefit Description

Physical, Occupational and Speech Therapy

Habilitative Services

We cover habilitative services and devices to develop, improve, or maintain skills and functioning for daily living that were never learned or acquired to a developmentally appropriate level. Skills and functioning for daily living, such as basic activities of daily living, are typically learned or acquired during childhood development.

Habilitative services and devices include:

- Audiology services,
- Occupational therapy,
- Physical therapy,
- Speech-language therapy,
- Vision services, and
- Devices associated with these services including augmentative communication devices, reading devices, and visual aids.

Prescription Drugs

Self-Administered Drugs in accordance with USPSTF

We cover U.S. Preventive Services Task Force (USPSTF) recommended drugs, including mail order, in accordance with the Patient Protection and Affordable Care Act provided the drug quantity prescribed does not exceed (i) a 30-consecutive-day supply, or (ii) an amount as determined by the Health Plan formulary. Mail order is provided up to a 90-consecutive-day supply to your home. The mail order program does not apply to certain pharmaceuticals (such as controlled substances as determined by state and/or federal regulations, bulky items, medication affected by temperature, injectables, and other products and dosage forms as identified by the Kaiser Permanente Pharmacy and Therapeutics Committee). Mail order drugs will not be sent to addresses outside of the Service Area.

Special Services for Women

Family Planning Visits

We cover family planning services in accordance with the Patient Protection and Affordable Care Act.

Behavioral Health – Mental Health and Substance Abuse

We cover conditions listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association that meet the standards of Medical Necessity.

Emergency Services from Dentists

We cover services of dentists only when the dentist performs emergency or surgical services that could also be performed by a Physician.

Miscellaneous Medical Treatments

Erectile Dysfunction

We cover services approved by Health Plan for the treatment of erectile dysfunction due to an organic cause.

Temporomandibular Joint Dysfunction (TMJ)

We cover services for the treatment of temporomandibular joint dysfunction (TMJ).

Vision Appliances and Procedures

We cover vision appliances, including eyeglasses and contact lenses and vision procedures for certain medical conditions when prescribed by a Physician.

Pediatric Vision Care

We cover pediatric vision care services for Members up to age 19, as follows:

- One eye examination per Accumulation Period.
  Please note: Additional eye exams are covered at the usual office visit Cost Share.
- When prescribed by a Kaiser Permanente Optometrist or Physician, one pair of polycarbonate single vision, lined bifocal or lined trifocal lenses per Accumulation Period.
- One frame every Accumulation Period. Covered frames must be from the "value collection frames" available at Vision Essentials by Kaiser Permanente clinic locations.
- (in lieu of frames and lenses) One pair of non-disposable contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing) not more than once every 12 months is provided at no charge. Covered contact lenses include:
    - Standard (one pair annually): one contact lens per eye (total of two lenses), or
    - Monthly (six-month supply): six lenses per eye (total of 12 lenses), or
    - Bi-weekly (three-month supply): six lenses per eye (total of 12 lenses), or
    - Dailies (one-month supply): 30 lenses per eye (total of 60 lenses).

Medically necessary contact lenses, when determined by a Physician. Contact lenses may be medically necessary and appropriate in the treatment of certain conditions such as Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular, and Astigmatism.

One low vision hand-held or page magnifier device (including fitting and dispensing) is provided every 24 months.

Services Not Covered

Miscellaneous Exclusions

Habilitative Services: You are not covered for:

- Rehabilitation Programs, unless referred by a Physician;
- Unskilled therapy;
- Routine vision services; and

- Duplicate services provided by another therapy or available through schools and/or government programs

Erectile Dysfunction: You are not covered for drugs, injections, equipment, supplies, prosthetics, devices and aids related to treatment of erectile (sexual) dysfunction, except as described in this Rider.

Additional Provisions

Miscellaneous Provisions

Essential Health Benefits (EHBs)
Essential Health Benefits (EHBs) are benefits that the U.S. Department of Health and Human Services (HHS) Secretary defines as essential health benefits. EHBs include ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse 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 the EHB-benchmark plan. These EHBs are subject to change at any time to conform to applicable laws and regulations. This list is available through our Member Services department.

Health Plan certifies that this EOC covers Essential Health Benefits to the full extent required by law, except pediatric oral care services are not covered. Coverage for pediatric oral care should either be obtained via a stand-alone (independent) dental plan or via a "bundled" qualified health plan (QHP) purchased from Kaiser Permanente Hawaii Region (if purchased through us, the benefit will be described in the Benefit Summary in the front of this Guide), in accordance with applicable law. "Bundled" qualified health plans are medical plans that have been certified and approved as a QHP, in accordance with the Patient Protection and Affordable Care Act, and are bundled with a stand-alone exchange-certified pediatric dental plan from Hawaii Dental Service (HDS). Information regarding dental benefits should be obtained directly from HDS.

All other terms of coverage in this EOC applicable to Essential Health Benefits remain effective, including but not limited to the Exclusions and Limitations section of this EOC and the requirement that covered services be provided by or arranged by a Physician and be provided at a Medical Office, Hospital or Skilled Nursing Facility, except where such terms of coverage are specifically limited in this EOC (such as for emergency services) or would violate applicable law.

EHBs are provided upon payment of any applicable Deductible and Cost Shares listed in the Benefit Summary in the front of this Guide.

This section describes EHBs that are not described in other parts of this Guide. These EHBs are subject to all coverage requirements described in other parts of this EOC.

Payments toward EHBs count toward your Annual Copayment Maximum described in the Benefit Summary found in the front of this Guide and Chapter 2: Payment Definitions and Information.

Kaiser Foundation Health Plan, Inc. – Hawaii Prescription Drug Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

Note: We also cover some outpatient drugs and supplies in the Prescription Drugs section in *Chapter 3: Benefit Description* of this Guide.

For Senior Advantage members, this Rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage (EOC).*

Benefit Summary

Description	Cost Share
Self-administered Prescription Drugs (member-purchased outpatient drugs at Kaiser Permanente Pharmacies)	
Generic maintenance drugs *	$3
Other Generic drugs *	$12
Brand-name drugs *	$50
Specialty drugs *	$200
Refills through Mail-Order Program (for up to a 90-consecutive-day supply)	
Generic maintenance drugs	Two times the above-listed copay
Other Generic drugs	Two times the above-listed copay
Brand-name drugs	Two times the above-listed copay
Specialty drugs *	$200
Insulin – other generic	$12
Insulin – brand name	$50
Annual Prescription Drug Copayment Maximum (on Pharmacy Dispensed Drugs)	
• Member	$5,000
• Family Unit	$10,000 (2 or more members)

Description	Cost Share
Well Rx Program drugs*	Not applicable

* For up to a 30-consecutive-day supply per prescription, or an amount as determined by the Kaiser Permanente formulary.

Benefit Description

Self-administered Prescription Drugs (member-purchased outpatient drugs at Kaiser Permanente Pharmacies)

Covered Drugs and Supplies
We cover self-administered prescription drugs and supplies only if all of the following conditions are met:

- prescribed by a KP physician or licensed Prescriber,
- is a drug for which a prescription is required by law, except for insulin,
- obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate,
- listed on the Kaiser Permanente formulary and used in accordance with formulary guidelines or restrictions, and Senior Advantage members with Medicare Part D are entitled to drugs on the Kaiser Permanente formulary and Kaiser Permanente Hawaii Medicare drug formulary, and
- is a drug which does not require administration by nor observation by medical personnel.

Notes: Immunizations are described in *Chapter 3: Benefit Description* under *Routine and Preventive.* Contraceptive drugs and devices are described in *Chapter 3: Benefit Description* under *Routine and Preventive.* Diabetic equipment and supplies are described in *Chapter 3: Benefit Description* under *Durable Medical Equipment (DME)* and *Prescription Drug*.

Cost Share for Covered Drugs and Supplies
When you get a prescription from a Kaiser Permanente Pharmacy, pharmacy we designate, or order a prescription from our Kaiser Permanente Mail-Order Pharmacy, you pay the Cost Share as shown in the above Benefit Summary. A reasonable charge is made for prescribed quantities in excess of the amounts described in the Benefit Summary. Each refill of the same prescription will also be provided at the same charge.

The Cost Share amounts count toward the Annual Copayment Maximum (or the Annual Prescription Drug Copayment Maximum if you have one listed in the above Benefit Summary). This applies for each covered prescription.

If you get a prescription from a non-Kaiser Permanente pharmacy, you will be responsible for 100% of the charges because it is not covered under this Prescription Drug Rider.

Day Supply Limit
The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that

constitutes a Medically Necessary 30-consecutive-day (or any other number of days) supply for you. Dispensing limitations may apply within the 30-consecutive-day supply period for certain drugs. When you pay the Cost Share shown in the Benefit Summary, you will receive the prescribed supply up to the day supply limit.

How to Get Covered Drugs or Supplies

Our pharmacies are located in most Kaiser Permanente clinics. To find a pharmacy, please see your Caring for You: Physicians and Locations Directory, visit kp.org, or contact Member Services. You must present your KP membership ID card, which has your medical record number, and a photo ID to the pharmacist.

Our mail-order pharmacy offers postage-paid delivery for refills of Maintenance drugs. Some drugs and supplies are not available through our mail-order pharmacy and/or not eligible for the mail-order cost share. Examples include but are not limited to controlled substances as determined by state and/or federal regulations, bulky items, drugs that require special handling or refrigeration, injectables, and other products and dosage forms as identified by the Kaiser Permanente Pharmacy and Therapeutics Committee. Drugs and supplies available through our mail-order pharmacy are subject to change at any time without notice. We are not licensed to mail medications out of state, so mail order drugs will not be mailed to addresses outside of the Service Area.

If you would like to use our mail-order pharmacy, use one of the methods below:

- Register and order online securely at **kp.org/refill**
- Call our Mail-order Pharmacy at **(808) 643-7979** (TTY **711**), Monday through Friday, 8 a.m. to 5 p.m.

Definitions

The following terms, when capitalized and used in this Prescription Drug Rider mean:

- ***Brand-name Drug***. The first U.S. Food and Drug Administration (FDA) approved version of a drug. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent. 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).
- ***Generic Drug.*** A drug that contains the same active ingredient as a Brand-Name Drug, is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent, and having the same active ingredients(s) as the Brand-name Drug. Generic Drugs are produced and sold under their Generic names after the patent of the Brand-Name drug expires. Generally, Generic Drugs cost less than Brand-Name Drugs, and must be identical in strength, safety, purity, and effectiveness.
- ***Generic Maintenance Drug.*** A specific Generic Drug to treat chronic conditions and is on Health Plan's approved list. Note: Not all Generic Drugs to treat chronic conditions are considered Generic Maintenance Drugs.
- ***Maintenance Drug.*** A drug to treat chronic conditions, such as asthma, high blood pressure, diabetes, high cholesterol, cardiovascular disease, and mental health.
- ***Specialty Drug.*** A very high-cost drug approved by the U.S. Food and Drug Administration (FDA).
- ***Annual Prescription Drug Copayment Maximum.*** (If not specified in this Benefit Summary, does not apply.) The Annual Prescription Drug Copayment Maximum is the maximum amount for Pharmacy Dispensed Drugs you pay out of your pocket in a calendar year. Once you meet the Annual Prescription Drug Copayment Maximum, you are no longer responsible for Cost Share amounts for covered Pharmacy Dispensed Drugs for the remainder of that calendar year. For Senior Advantage members, please see Chapter 6 in your Medicare Evidence of Coverage.

- "Pharmacy Dispensed Drugs" include all covered safe to self-administer pharmacy dispensed drugs, including but not limited to inhalers, insulin, chemotherapy drugs, contraceptive drugs/devices, and tobacco cessation drugs.
- All incurred Cost Share and prescription drug deductibles (if applicable) for Pharmacy Dispensed Drugs count toward the Annual Prescription Drug Copayment Maximum, and are credited toward the calendar year in which they were received.
- Note: The following medical items count toward the Annual Copayment Maximum and not the Annual Prescription Drug Copayment Maximum: skilled administered drugs, diabetes supplies to operate diabetes equipment, lancets, syringes, and drugs that are not dispensed from the pharmacy because they are not safe to self-administer.
- Payments made by you or on your behalf for non-covered services, or for benefits excluded under this EOC do not count toward the Annual Copayment Maximum nor the Prescription Drug Copayment Maximum.
- It is recommended that you keep receipts as proof of your payments. All payments are credited toward the calendar year in which the services were received.

- ***Annual Prescription Drug Deductible.*** (If not specified in this Benefit Summary, does not apply.) The Annual Prescription Drug Deductible is the amount you must pay for certain types of self-administered prescription drugs in a calendar year before we will cover those drugs. Once you meet the Annual Prescription Drug Deductible, you are no longer responsible for prescription drug deductible amounts for the remainder of the calendar year, and you pay the Cost Share shown in the Benefit Summary.
  - Each Member must meet the "per Member" Annual Prescription Drug Deductible, or the Family Unit must meet the "family unit" Annual Drug Deductible.
  - The "per Member" Annual Prescription Drug Deductible amount counts toward the "per family unit" Annual Prescription Drug Deductible amount. Once the "per Member" Annual Prescription Drug Deductible is satisfied, no further Annual Prescription Drug Deductible will be due for that Member for the remainder of the calendar year. Once the "per family unit" Annual Prescription Drug Deductible is satisfied, no further "per Member" Prescription Drug Deductibles will be due for the remainder of the calendar year.
  - The Annual Prescription Drug Deductible is separate from any other deductible that may be described in the Benefit Summary in the front of this Guide. Payments toward the Annual Prescription Drug Deductible do not count toward any other deductible. Consequently, payments toward any other deductible do not count toward the Annual Prescription Drug Deductible.
  - Payments toward the Annual Prescription Drug Deductible also count toward the limit on Annual Prescription Drug Copayment Maximum.
- **Well Rx Program.** The WellRx Program is a program that meets all of the following criteria:
  - applies to non-Medicare Members who have been identified through Kaiser Permanente's disease registries as eligible for the WellRx Program,
  - these Members may receive their 30-consecutive-day supply of a self-administered chronic disease drug or diabetes supply without charge, and
  - only certain chronic disease drugs identified on the Health Plan formulary are available as part of this program, and the eligible drugs are subject to the same requirements as self-administered drugs.

About Our Drug Formulary

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/specialty drug unless this is prohibited by your Kaiser Permanente physician. If you want a brand-name/specialty 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 Cost Share. If you request the higher priced drug and it has not been deemed Medically Necessary, you will be charged Member Rates.

Note: If your prescription allows refills, there are limits to how early you can receive a refill. We will refill your prescription when you have used at least 75 percent of the quantity, unless otherwise directed by Kaiser Permanente. Please ask your pharmacy if you have questions about when you can get a covered refill.

Services Not Covered

- 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 *Chapter 3: Benefit Description* under *Prescription Drugs*.
- Drugs in the same therapeutic category as the non-prescription drug, as approved by the Kaiser Permanente Pharmacy & Therapeutics Committee.
- 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, except Senior Advantage Members with Medicare Part D covers syringes and needles under this Prescription Drug Rider. This exclusion does not apply to diabetes supplies as described in *Chapter 3: Benefit Description* under *Diabetic Supplies*.
- Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate.
- Brand-name/specialty 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 not included on the Health Plan formulary, unless a non-formulary drug has been specifically prescribed and authorized by the licensed Prescriber.
- Drugs to shorten the duration of the common cold.
- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Drugs and supplies to treat sexual dysfunction.
- Drugs used to enhance athletic performance (including weight training and body building).
- Replacement of lost, stolen or damaged drugs or supplies.

Kaiser Foundation Health Plan, Inc. – Hawaii
Infertility Treatment Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage (EOC).*

Benefit Summary

Description	Cost Share
Special Services for Women	
Artificial insemination (intrauterine insemination)	Office visit copay

Benefit Description

Special Services for Women

Artificial Insemination

We cover artificial insemination (intrauterine insemination) to determine infertility status in accord with Medical Group requirements and criteria.

Kaiser Foundation Health Plan, Inc. – Hawaii
Maternity Care Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage (EOC).*

Benefit Summary

Description	Cost Share
Special Services for Women	
Maternity	
• Maternity Care - delivery	None
• Maternity and Newborn Inpatient Stay	None
Total Care Services	
Observation	None

Benefit Description

Maternity Care
Covered, for delivery.

Maternity and Newborn Inpatient Stay
You have inpatient benefits for maternity as follows:

- 48 hours from time of delivery for a vaginal labor and delivery/ or
- 96 hours from time of delivery for a cesarean labor and delivery.

All newborns are covered for nursery care services described in Chapter 3 for the first 48 or 96 hours after birth. For a description of covered services see the *Inpatient Hospital* section in Chapter 3. Newborns are covered after the first 48 or 96 hours if added to your coverage within 31 days of birth.

Newborns with congenital defects and birth abnormalities are covered for the first 31 days of birth even if not added to your coverage. These newborns are covered after 31 days of birth only if added to your coverage within 31 days of birth. See *Chapter 6: Membership Information.*

Observation
Covered when prescribed by a Physician.

Kaiser Foundation Health Plan, Inc. – Hawaii
Primary Care Office Visits for Children Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage (EOC).*

Benefit Summary

Description	Cost Share
Primary Care Office Visits for Children	
Primary care office visits for children through age 17	None

Benefit Description

Primary Care Office Visits for Children

Covered, for Members from birth through age 17 to treat illness and injury. Primary care must be received from a primary care provider at a Medical Office.

Notes:

- Specialty care office visits for Members (from birth through age 17) are covered upon payment of your Specialty Care Cost Share listed in the *Benefit Summary* in the front of this Guide.
- Well-child care office visits are covered at no charge as listed in the *Benefit Summary* in the front of this Guide. Well-child care office visits are described in *Chapter 3: Benefit Description*, Routine and Preventive section.
- For Members age 18 and older, primary care office visits are covered upon payment of the same office visit Cost Share listed in the *Benefit Summary* in the front of this Guide.

Kaiser Foundation Health Plan, Inc. – Hawaii

Kaiser Permanente Fit Rewards

This amendment is part of the *Guide to Your Health Plan* (Guide) to which it is attached. This amendment becomes part of *Chapter 5: Wellness and Other Special Features under the Extra Services section*. The provisions of this Guide and the Evidence of Coverage (EOC) apply to this amendment. Kaiser Permanente Fit Rewards is a value-added program and not part of your medical benefits.

Kaiser Permanente Fit Rewards® Program provides these extra services

Kaiser Permanente Fit Rewards – Calendar Year	**Basic Program fitness club and exercise center membership program** • Eligible Members may enroll with an American Specialty Health, Inc. (ASH) contracted network fitness club • Program enrollment includes standard fitness club services and features including access to cardiovascular equipment, access to resistance/strength equipment, access to classes which are routinely included in the general membership fee as part of the monthly fee, and for which the contracted fitness club does not typically require a fee per session, per week, per month, or some other time period; and where available, amenities such as saunas, steam rooms, and whirlpools. • Eligible Members should verify services and features with ASH contracted fitness club **Note:** • Eligible members must pay the Fit Rewards $200 annual program fee ✦ • Eligible members must meet the 45-day, 30-minute per session activity requirement by end of calendar year 2024	**No Charge**
	Or	
	Home Fitness Program • Eligible Members may select up to one of the available ASH home fitness kits per calendar year	**$10** ✦
	Active&Fit website • All eligible Members have access to Active&Fit web-based services such as facility provider search, enrollment functions, educational content and fitness tools and trackers.	

The following are excluded from the Active&Fit Program:

- Instructor-led classes for which the ASH contracted fitness club charges a separate fee (and which are not routinely included in the general membership fee as part of the monthly membership fee).
- Personal trainers, classes, and club services, amenities, and products or supplies for which the ASH contracted fitness club charges Members an additional fee.
- Access to fitness or exercise clubs that are not part of ASH's contracted network.
- Home fitness kits not provided through ASH's Active&Fit program.
- Enrollment for Members not specifically listed as eligible for this program, as defined by the Group and Kaiser Permanente.
- 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 Annual Copayment Maximum.

Kaiser Permanente shall not undertake to provide or to assure the availability and access to gym facilities approved by ASH.

Kaiser Permanente Fit Rewards is part of the Active&Fit Program, administered by American specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit and the Active&Fit logo are federally registered trademarks of ASH and used with permission herein. The details of this program are subject to change. For the most current details and specifics, please visit kp.org/fitrewards.

Kaiser Foundation Health Plan, Inc. – Hawaii

Hearing Aid Rider – 20%

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage (EOC).*

	Benefits	You pay
	Up to 2 hearing aid(s), one for each hearing-impaired ear, once every 36 months, when prescribed by a Kaiser Permanente physician or Kaiser Permanente audiologist, and obtained from sources designated by Health Plan. **Limitations:** • Coverage is limited to the lowest priced model hearing aid in accordance with Kaiser's guidelines that adequately meets the medical needs of the Member. • Hearing aids above the lowest priced model will be provided upon payment of the applicable charges that the Member would have paid for a lowest priced model hearing aid plus all additional charges for any amount above the lowest priced model hearing aid. **Exclusions:** • All other hearing aid related costs, including but not limited to: consultation, fitting, rechecks and adjustments for the hearing aid(s).	20% of applicable charges

Kaiser Foundation Health Plan, Inc. – Hawaii

Optical $200 Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage (EOC).*

Benefit Summary

Description	Cost Share
Optical Eyewear and Services	
Glasses frame/lens, lens treatments OR Contact lens/contact lens exam and fitting services	All costs greater than the $200 allowance per Accumulation Period
Medically required contact lenses	None
Pediatric Vision Care *	
Eye examination	None
One pair of polycarbonate single vision, lined bifocal or lined trifocal lenses	None
One frame	None
(in lieu of frames and lenses) one pair of non-disposable contact lenses or an initial supply of disposable contact lenses	None
Medically necessary contact lenses	None
One low vision hand-held or page magnifier device	None

* The benefits listed under Pediatric Vision Care section are limited to pediatric Members up to age 19. Such Members may combine their Pediatric Vision Care benefit and the allowance under Optical Eyewear and Services. See options under Pediatric Vision Care section.

Benefit Description

Optical Eyewear and Services and Pediatric Vision Care generally

Optical services must be received at, and optical eyewear must be purchased at Vision Essentials at Kaiser Permanente locations in order to be covered.

The allowances are a one-time benefit per Accumulation Period. If the entire allowance is not used during your initial visit, any unused portion of the allowance cannot be used for the remainder of that Accumulation Period and will not be carried forward to the next Accumulation Period.

Your allowance and any payments toward eyewear and services do not count toward the Annual Copayment Maximum.

We also cover routine eye examinations for eyeglasses in the Routine and Preventive section in *Chapter 3: Benefit Description* of this Guide. We also cover diagnosis, treatment and continued care for conditions related to disease or injuries of the eye by an eye specialist in the Office Visits section in *Chapter 3: Benefit Description* of this Guide. We also cover care in the hospital in the Total Care Services section in *Chapter 3: Benefit Description* of this Guide.

Optical Eyewear and Services

You must choose to use your allowance toward either glasses or contacts.

Glasses frame/lens, lens treatments, prescription safety glasses, corrective sunglasses
Covered. For members up to age 19, the lens material will be impact resistant polycarbonate.

Contact lens/contact lens exam and fitting services (when in lieu of frames and lenses)
Covered, for initial and refit of contact lens.

Medically required contact lenses
Covered, when medically required upon the prescription of a Kaiser Permanente Optometrist or Physician, that the contact lenses will provide a significant improvement in visual acuity or binocular vison not obtained with regular lenses. Thereafter, whenever a change in correction in either or both lenses is prescribed by a Kaiser Permanente Optometrist or Physician, lens or lenses with the new correction will be provided without charge.

Pediatric Vision Care

You must choose to use your pediatric vision care benefit for either glasses or contacts.

Eye examination
Covered, once per Accumulation Period.
Note: Additional eye examinations are covered at the usual office visit Cost Share in *Chapter 3: Benefit Description* of this Guide.

One pair of polycarbonate single vision, lined bifocal or lined trifocal lenses
Covered, once per Accumulation Period, when prescribed by a Kaiser Permanente optometrist or Physician. For members up to age 19, the lens material will be impact resistant polycarbonate.

One frame
Covered, once per Accumulation Period. Frame must be from the "value collection frames" available at Vision Essentials by Kaiser Permanente locations.

One pair of non-disposable contact lenses or an initial supply of disposable contact lenses (when in lieu of frames and lenses).
Covered, once per Accumulation Period. Includes fitting and dispensing of contact lenses. Covered contact lenses include:

- Standard (one pair annually): one contact lens per eye (total of two lenses), or
- Monthly (six-month supply): six lenses per eye (total of 12 lenses), or
- Bi-weekly (three-month supply): six lenses per eye (total of 12 lenses), or
- Dailies (one-month supply): 30 lenses per eye (total of 60 lenses)

Medically necessary contact lenses
Covered, when determined to be medically necessary by a Kaiser Permanente Optometrist or Physician. Contact lenses may be medically necessary and appropriate in the treatment of certain conditions such as Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular, and Astigmatism.

One low vision hand-held or page magnifier device
Covered, once every 24 months. Device includes fitting and dispensing.

Pediatric Vision Care options

Pediatric Members up to age 19 may combine the Pediatric Vision Care benefit and the allowance under Optical eyewear and services. Select one of these options:

- Eyeglasses: If pediatric Member chooses one pair of lenses and one frame from the "value collection", the eyeglass allowance may be applied toward this same or an additional pair of eyeglasses.
- Eyeglasses not from the "value collection": Instead of "value collection" frame, pediatric Members may apply the combined value of one pair of lenses and one frame from the "value collection" toward eyeglasses that are not from the "value collection." The eyeglass allowance may be applied toward this same pair of eyeglasses.
- Contact lenses: If pediatric Member chooses contact lenses, the contact lens allowance is applied toward additional contact lenses.

Services Not Covered

- Non-prescription eyewear such as colored contact lenses, non-prescription athletic eyewear, industrial safety, and non-prescription sunglasses
- Any medical services or eyewear from non-Kaiser Permanente providers or non-Kaiser Permanente optical facilities
- Contact lens exams (if the allowance has been exhausted)
- All costs exceeding the stated allowance in the *Benefit Summary*.

Kaiser Foundation Health Plan, Inc. – Hawaii
Kaiser Permanente – Small Group Dental 2995 (Bundled Dental)

This rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this rider.

For Senior Advantage members, this rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage* (EOC).

The following amends part of *Chapter 4: Services Not Covered:*

Dental Care: You are not covered for dental care Services, except as described in this rider.

All benefits are governed by the provisions of Kaiser Foundation Health Plan, Inc.'s (Kaiser) Agreement with Hawaii Dental Service (herein referred to as "HDS") and HDS's procedure code guidelines. If there are inconsistencies, then the agreement between Kaiser and HDS shall govern. All dental claims must be filed within 12 months of the date of service for HDS claims payment.

A description of the HDS dental benefits covered under the "Kaiser Permanente Small Group Dental: HDS Group Number 2995" stand-alone dental plan was provided to Kaiser Permanente directly from HDS and is on the following page *"Summary of Dental Benefits"*.

DELTA DENTAL

HDS
Hawaii Dental Service

Summary of Dental Benefits
Kaiser Small Group Plan - Group No. 2995
Effective: 01/01/2024

This summary is a brief description of a Hawaii Dental Service (HDS) member's dental benefits. Some limitations, restrictions, and exclusions may apply. Plan benefits are governed by the provisions detailed in the group's and/or subscriber's agreement with HDS, HDS's Procedure Code Guidelines and Delta Dental National Policies when applicable. Certain provisions may vary across group agreements such as waiting periods, frequency and age limitations, etc. and may not be included in this summary. For additional information, please contact HDS Customer Service. As an HDS member, you may visit any licensed dentist, but your out-of-pocket costs may be lower when visiting an HDS participating dentist. All dental claims must be filed within 12 months of the date of service to be eligible for HDS claims payment.

	ADULTS - AGE 19 & OLDER	CHILDREN – AGE 18 & UNDER
PLAN MAXIMUM The most HDS will pay for each person for all covered dental services performed during the calendar year.	**$1,200 per yr**	**N/A**
MAXIMUM OUT OF POCKET (MOOP) The most you will pay before your dental plan begins to pay 100% of your benefit. Out-of-pocket payments made for non-covered services, alternate benefits and non-medically necessary orthodontics will not count toward the MOOP.	**N/A**	**$400 per child per yr $800 for 2+ children per yr**
	HDS PLAN PAYS	
DIAGNOSTIC		
Examinations	**100%** 2x/yr	**100%** 2x/yr
Bitewing X-rays	**100%** 1x/yr	**100%** 2x/yr
Other X-rays	**70%** Full mouth X-rays 1x/5 yrs	**70%** Full mouth X-rays 1x/5 yrs
PREVENTIVE		
Cleanings	**100%** 2x/yr	**100%** 2x/yr
Fluoride	**Not Covered** N/A	**100%** 2x/yr Through age 18
Silver Diamine Fluoride	**100%**	**100%**
Space Maintainers	**Not Covered** N/A	**100%** Through age 18

Sealants One treatment per tooth per lifetime to permanent molar teeth when there are no prior fillings on biting surfaces.	Not Covered	100% Through age 18
TOTAL HEALTH PLUS BENEFITS		
If the member has multiple conditions, they will only be eligible for the benefit with the most cleaning(s) and/or gum maintenance treatments of a single condition. All benefits are covered at 100% unless otherwise noted.		
Diabetes • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Cancer (other than Oral) • Cleanings/Gum Maintenance • Fluoride Treatments	Additional 2x/yr Additional 2x/yr	Additional 2x/yr Additional 2x/yr
Oral Cancer • Cleanings/Gum Maintenance • Fluoride Treatments	Additional 2x/yr Additional 4x/yr	Additional 2x/yr Additional 4x/yr
Sjogren's Syndrome • Cleanings/Gum Maintenance • Fluoride Treatments	Additional 2x/yr Additional 4x/yr	Additional 2x/yr Additional 4x/yr
Stroke • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Heart Attack, Congestive Heart Failure • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Kidney Failure • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Organ Transplant • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Pregnancy (Expectant Mothers) • Cleanings/Gum Maintenance	Additional 1x/yr	Additional 1x/yr
Medical Risk for Cavities • Fluoride Treatments	Additional 3x/yr	Additional 3x/yr
BASIC CARE		
Fillings Once every two years per tooth per surface.	70% White-colored fillings limited to front teeth.	70% White-colored fillings limited to front teeth.
Root Canals	70%	70%
Gum/Bone Surgeries & Maintenance (non-medical risk factors) Once every three years per quad.	70%	70%
Oral Surgeries	70%	70%
MAJOR CARE		
Crowns	50% 1x/7yrs per tooth White crowns limited to front teeth and bicuspids.	50% 1x/7yrs per tooth White crowns limited to front teeth and bicuspids.

Fixed Bridges & Dentures	50% 1x/7yrs per tooth	50% 1x/7yrs per tooth
Implants	50%	Not Covered
OTHER SERVICES		
Adjunctive General Services	70%	70% Nitrous Oxide, IV sedation and hospital care is covered.
Emergency Treatment of Dental Pain (Palliative Treatment) Once per visit per dental office for relief of pain but not to cure	70%	70%
Athletic Mouth Guards	Not Covered	70% 1x/24-months
ORTHODONTICS		
	50% For dependent children through age 25. $1000 lifetime maximum amount paid (eight quarterly payments)	50% For dependent children through age 25. $1000 lifetime maximum amount paid (eight quarterly payments)
Medically Necessary Ortho Limited to dependent children for those cases involving repair of the cleft lip and/or cleft palate, severe facial birth defects, or an incurred injury that affects the function of speech, swallowing, and/or chewing.	Not Covered	50% Through age 18

CHILDREN – AGE 18 & UNDER: Special Consideration: Assessment of salivary flow is covered. Orthodontic services are not covered if services were started prior to the date the patient became eligible under this employer's plan. If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred. Self-administered or at-home applications (or any type of "do it yourself") orthodontics is not a covered benefit. Orthodontics must be performed by a licensed dentist or supervised staff.

ADULTS – AGE 19 & OLDER: Special Consideration: Assessment of salivary flow is covered. Orthodontic services are not covered if services were started prior to the date the patient became eligible under this employer's plan. If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred. Self-administered or at-home applications (or any type of "do it yourself") orthodontics is not a covered benefit. Orthodontics must be performed by a licensed dentist or supervised staff.

Access to HDS Information 24/7

Visit HDS Online at HawaiiDentalService.com to:

ACCESS YOUR ACCOUNT

- *Visit HawaiiDentalService.com*
- *Click "Member Login"*
- *Click "Create an account"*
- *Complete the "Account Registration" form*
- *Select "Yes" to be notified via e-mail when a claim is processed and "Yes" to "Request electronic Explanation of Benefits"*
- *Click "Register"*

SEARCH

- *For an HDS participating dentist in Hawaii, Guam or Saipan by specialty, location, handicap accessibility, weekend hours, and more*
- *For a Delta Dental Premier participating dentist on the Mainland or Puerto Rico by specialty, location, weekend hours and more*

DOWNLOAD & PRINT

- *A summary of your benefits for tax purposes*
- *Blank claim forms*
- *Your HDS membership card*
- *Your EOB statements*
- *HDS Notice of Privacy Practices*

CHECK

- *Whether you and/or your dependents are eligible for HDS benefits*
- *What dental services are covered by your plan*
- *What the limits are of each type of covered service and how much you have used*

VIEW

- *Your Explanation of Benefits (EOB) statements*
- *A list of frequently asked questions*
- *HDS contact information*

REQUEST

- *To receive emails when your claims are processed*
- *To receive EOB statements via email*
- *An HDS membership card to be mailed to you*

How to Contact HDS

Customer Service Representatives

From Oahu: (808) 529-9248

Toll-free: 1-844-379-4325

Customer Service Call Center Hours:

Monday – Friday: 7:30 AM – 4:30 PM HST

Excluding HDS observed holidays,

visit HawaiiDentalSevice.com/about/holidays

for our HDS' observed holiday schedule.

Walk-in Office Hours:

Monday – Friday: 8:00 AM – 4:30 PM HST

Send Written Correspondence to:

Hawaii Dental Service

Attn: Customer Service

900 Fort Street Mall, Suite 1900

Honolulu, HI 96813-3705

E-mail: CS@HawaiiDentalService.com

FAX:

From Oahu: (808) 529-9366

Toll-free fax: 1-866-590-7988

Kaiser Foundation Health Plan, Inc. – Hawaii

Alternative Medicine Rider E - 20 visits/$20

This Rider is included in the Benefit Summary in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage* (EOC).

Benefit Summary

Description	Cost Share
Chiropractic, acupuncture, massage therapy and naturopathy services	
Up to a maximum of 20 office visits per calendar year. **This Rider does not cover services which are performed or prescribed by a Kaiser Permanente physician or other Kaiser Permanente health care provider.** Services must be performed and received from Participating Chiropractors, Participating Acupuncturists, Participating Massage Therapists, and Participating Naturopaths of **American Specialty Health (ASH)**. Covered Services include: • **Chiropractic services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders which are authorized by ASH and performed by a Participating Chiropractor. • **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. • **Massage therapy services** for the treatment and diagnosis of myofascial/musculoskeletal disorder, a musculoskeletal functional disorder, pain syndromes or lymphedema which are referred by a Participating Chiropractor or Kaiser Permanente Physician, authorized by ASH and performed by a Participating Massage Therapist. • **Naturopathy services** limited to noninvasive modalities such as diathermy, electrical stimulation, hot and cold packs, hydrotherapy, manipulation, range of motion exercises, and therapeutic ultrasound which are authorized by ASH and performed by a Participating Naturopath. • **Adjunctive therapy** as set forth in a treatment plan approved by ASH, which 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. • **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, Participating Naturopath who is acting within the scope of their license or certification under applicable law, 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 or Participating Naturopath and authorized by ASH.	$20 copayment per office visit

Description	Cost Share
Chiropractic appliances when prescribed and provided by a Participating Chiropractor and authorized by ASH.	Payable up to a maximum of $50 per calendar year

Benefit Description

- This Alternative Medicine Rider does not cover Services which are performed or prescribed by a Hawaii Permanente Medical Group (herein referred to as "HPMG") physician, but instead refer to services performed or prescribed by a Health Plan Designated Network's Participating Chiropractor, Participating Acupuncturist, Participating Massage Therapist, and Participating Naturopath. Medically necessary services performed or prescribed by a Hawaii Permanente Medical Group physician are covered in accordance with this EOC, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law.
- Alternative medicine services are provided as described in this Rider. Alternative medicine services listed in this Rider are covered only if Medically Necessary and received from the Health Plan Designated Network's (herein referred to as "Designated Network") Participating Chiropractors, Participating Acupuncturists, Participating Massage Therapists, and Participating Naturopaths.
- The Designated Network, Participating Chiropractors, Participating Acupuncturists, Participating Massage Therapists, Participating Naturopaths, HPMG, Kaiser Foundation Health Plan, Inc. (herein referred to as "Health Plan"), and Kaiser Foundation Hospitals are independent contractors. Health Plan, Kaiser Foundation Hospitals, HPMG and its Physicians shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by Members while receiving Chiropractic, Acupuncture, Massage Therapy, or Naturopathy Services. The Designated Network and Participating Chiropractors, Participating Acupuncturists, Participating Massage Therapists, and Participating Naturopaths are not agents or employees of Health Plan. Neither Health Plan nor any employee of Health Plan is an employee or agent of the Designated Network or Participating Chiropractors, Participating Acupuncturists, Participating Massage Therapists, or Participating Naturopaths. Participating Chiropractors, Participating Acupuncturists, Participating Massage Therapists, and Participating Naturopaths maintain the chiropractor-patient, acupuncture-patient, massage therapy-patient, and naturopath-patient relationship with Members and are solely responsible to Members for all Chiropractic, Acupuncture, Massage Therapy, or Naturopath Services under this Rider.

Definitions

As used in this Rider, the terms in boldface type, when capitalized, have the meaning shown:

- **Acupuncture Services:** Acupuncture Services are Services rendered or made available to a Member by a Participating Acupuncturist for treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea or Pain Syndromes.
- **Chiropractic Appliances**: Chiropractic Appliances are support type devices prescribed by a Participating Chiropractor. These shall be restricted to the following items to the exclusion of all others: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, support/lumbar braces/supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports and wrist braces.
- **Chiropractic Services:** Chiropractic Services are services rendered or made available to a Member by a Participating Chiropractor for treatment or diagnosis of Neuromusculo-skeletal Disorders.
- **Naturopathy Services:** Naturopathy services are services rendered or made available to a Member by a Participating Naturopath for therapy that is limited to noninvasive modalities such as diathermy, electrical stimulation, hot and cold packs, hydrotherapy, manipulation, range of motion exercises, and therapeutic ultrasound. There is a maximum of three therapies per approved date of service. Covered conditions and services are limited to those the Participating Naturopath is qualified to treat or perform pursuant to state licensure and scope of practice.

- **Chiropractic and Acupuncture Urgent Office Visits:** Chiropractic and Acupuncture Urgent Office Visits are Covered Services received in a Participating Chiropractor's office and rendered for the sudden unexpected onset of an injury or condition affecting the neuromuscular-skeletal system which manifests itself by acute symptoms of sufficient severity, including severe pain, which delay of immediate chiropractic or acupuncture attention could decrease the likelihood of maximum recovery.
- **Naturopathy Urgent Office Visits:** Naturopathy Urgent Office Visits are Covered Services rendered for the sudden unexpected onset of an injury or condition which manifests itself by acute symptoms of sufficient severity, including severe pain, for which delay of immediate naturopathy attention could decrease the likelihood of maximum recovery.
- **Copayments:** Payments to be collected directly by a Participating Chiropractor, Participating Acupuncturist, Participating Massage Therapist, or Participating Naturopath from a Member for Covered Services.
- **Covered Services:** Covered Services are Chiropractic Services, Acupuncture Services, Massage Therapy, or Naturopath Services as described in this Rider that are Medically Necessary Services.
- **Designated Network:** American Specialty Health, Inc.
- **Experimental or Investigational:** The Designated Network classifies a chiropractic, acupuncture, massage therapy, or naturopath service as experimental or investigational if the chiropractic, acupuncture, massage therapy, or naturopath service is investigatory or an unproven procedure or treatment regimen that does not meet professionally recognized standards of practice.
- **Massage Therapy Services.** Massage Therapy Services are services rendered by a Participating Massage Therapist for myofascial/musculoskeletal disorder, a musculoskeletal functional disorder, pain syndromes or lymphedema which are authorized by Designated Network.
- **Medically Necessary Services:** Medically Necessary Services are Chiropractic Services, Acupuncture Services, Massage Therapy, and/or Naturopath Services which are:
    - Necessary for the treatment of Neuromusculo-skeletal Disorders (chiropractic and acupuncture only); Pain Syndromes (acupuncture and massage therapy only); or Nausea (acupuncture only); or myofascial/musculoskeletal disorder, or musculoskeletal functional disorder (massage therapy only);
    - Established as safe and effective and furnished in accordance with professionally recognized standards of practice for chiropractic, acupuncture, massage therapy, or naturopathy.
    - Appropriate for the symptoms, consistent with the diagnosis, and otherwise in accordance with professionally recognized standards of practice; and
    - Pre-authorized by the Designated Network, except for an initial examination by a Participating Chiropractor, Participating Acupuncturist, Participating Massage Therapist, or Participating Naturopath.
- **Nausea:** Nausea is an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Participating Acupuncturist in accordance with professionally recognized standards of practice and includes post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy.
- **Neuromusculo-skeletal Disorders:** Neuromusculo-skeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related to neurological manifestations or conditions.
- **Pain Syndromes.** Pain Syndromes mean a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition.
- **Participating Acupuncturist:** A Participating Acupuncturist is an acupuncturist duly licensed to practice acupuncture in the State of Hawaii and who has entered into an agreement with Designated Network to provide Covered Services to Members.
- **Participating Chiropractor:** A Participating Chiropractor is a chiropractor duly licensed to practice chiropractic in the State of Hawaii and who has entered into an agreement with Designated Network

to provide Covered Services to Members.

- **Participating Massage Therapist:** A Participating Massage Therapist is a massage therapist duly licensed to practice massage therapy in the State of Hawaii and who has entered into an agreement with Designated Network to provide Covered Services to Members.
- **Participating Naturopath:** A Participating Naturopath is a naturopath duly licensed to practice naturopathy in the State of Hawaii and who has entered into an agreement with Designated Network to provide Covered Services to Members.

Services and Benefits

- Except for the initial examination by a Participating Chiropractor, Covered Services are limited to Chiropractic Services for the treatment or diagnosis of Neuromusculo-skeletal Disorders which are authorized and performed by a Participating Chiropractor.
- Except for the initial examination by a Participating Acupuncturist, Covered Services are limited to Acupuncture Services for the treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea or Pain Syndromes which are authorized and performed by a Participating Acupuncturist.
- Covered Services are limited to Massage Therapy Services for the treatment or diagnosis of myofascial/musculoskeletal pain syndromes which are referred by a Participating Chiropractor or Physician, authorized by Designated Network and performed by a Participating Massage Therapist.
- **Office Visits.**
    - Each visit to a Participating Chiropractor, Participating Acupuncturist, Participating Massage Therapist, or Participating Naturopath requires a Copayment as stated in the above *Benefit Summary*, which Members pay at the time of the visit. Members are entitled up to a combined maximum of visits per calendar year as stated in the above *Benefit Summary*.
    - Initial examination with a Participating Chiropractor, Participating Acupuncturist, or Participating Naturopath to determine the problem, and if Covered Services appear warranted, to prepare a treatment plan of services to be furnished. One initial exam will be provided for each new condition.
    - Subsequent office visits which are described in a treatment plan approved by the Designated Network which may involve manipulations, adjustments, therapy, and diagnostic tests listed below.
    - Reevaluation. During a subsequent office visit prescribed in the treatment plan or a separate visit, when necessary, the Participating Chiropractor, Participating Acupuncturist, or Participating Naturopath may perform a reevaluation examination to assess the need to continue, discontinue or modify the treatment plan.
    - Chiropractic, Acupuncture, or Naturopath Urgent Office Visits.
- **Diagnostic tests for Chiropractic and Naturopathy**. 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, radiological consultations, and clinical laboratory studies must be performed by either a Participating Chiropractor, Participating Naturopath who is acting within the scope of their license or certification under applicable state law, or staff member or referred to a facility that has been credentialed to meet the criteria of the Designated Network. Diagnostic tests must be performed or ordered by a Participating Chiropractor or Participating Naturopath and authorized by the Designated Network.
- **Chiropractic Appliances.** Chiropractic Appliances must be prescribed by a Participating Chiropractor and authorized by the Designated Network.
- **Adjunctive Therapy.** Adjunctive therapy, as set forth in a treatment plan approved by Designated Network, may involve chiropractic modalities (such as ultrasound, hot packs, cold packs, and electrical muscle stimulation), acupuncture therapies (such as acupressure, moxibustion, and cupping), and other therapies.

Services Not Covered

The exclusions and limitations listed in *Chapter 4: Services Not Covered* apply to this Rider. The following exclusions and limitations also apply:

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

- Services provided by a chiropractor, acupuncturist, massage therapist, or naturopath 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 the maximum limit (stated in the *Benefit Summary*) per calendar year.

What you need to know about your alternative medicine benefits

1. **Do I need to see my Kaiser Permanente physician to obtain a referral for a Participating Chiropractor, Participating Acupuncturist or Participating Naturopath?**
   No. These alternative medicine services do not require a Kaiser Permanente physician's approval.
2. **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.
3. **How do I choose a Participating Chiropractor, Participating Acupuncturist, Participating Massage Therapist, or Participating Naturopath?**
   You may select a Participating Chiropractor, Participating Acupuncturist, Participating Massage Therapist, or Participating Naturopath that participates with ASH. You may obtain a list with their addresses and phone numbers by calling the Kaiser Permanente Member Services Department at 1-800-966-5955. You may also view the list by logging on to our website at www.kp.org.
4. **How do I obtain chiropractic, acupuncture services, or naturopath services in Hawaii?**
   Simply select a Participating Chiropractor, Participating Acupuncturist, or Participating Naturopath and call to set-up an appointment. At your appointment, present your Kaiser Foundation Health Plan membership information card and pay your designated copayment.
5. **Will an X-ray be covered if it is ordered by the Participating 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 participating ancillary provider's office in order to be covered.