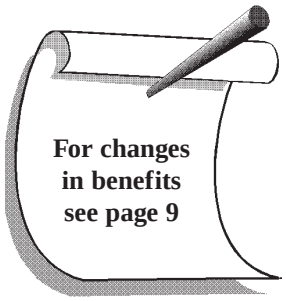
Kaiser Foundation Health Plan, Inc. - Hawaii Region

http://www.kaiserpermanente.org/hawaii

KAISER PERMANENTE®

2002

A Health Maintenance Organization



Serving: *Islands of Kauai, Maui, Oahu, and Hawaii (except for zip codes 96718, 96772, and 96777)*

Enrollment in this Plan is limited. You must live in our Geographic service area to enroll. See page 8 for requirements.

This Plan has excellent accreditation from the NCQA. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

631 High Option Self Only
632 High Option Self and Family
634 Standard Option Self Only
635 Standard Option Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees Health Benefits Program

RI 73-005

Table of Contents

Introduction

Kaiser Foundation Health Plan, Inc., Hawaii Region
711 Kapiolani Boulevard
Honolulu, Hawaii 96813

This brochure describes the benefits of Kaiser Foundation Health Plan, Inc., Hawaii Region under our contract (CS 1060) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for self and family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" or "Plan" means Kaiser Foundation Health Plan, Inc., Hawaii Region.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation, 1900 E Street NW, Washington, DC 20415.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 808/432-5955 or 800/966-5955 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Non-profit group practice, federally qualified health maintenance organization
- This Plan is part of the Kaiser Permanente Medical Care Program, a group of non-profit organizations and contracting medical groups that serve over 8 million members nationwide
- 44 years in existence
- Our three entities – Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and Hawaii Permanente Medical Group, Inc. (HPMG) – work together to provide you with a full range of medical care, benefits, and services
- We credential Plan providers according to national standards
- Our Moanalua Medical Center is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

If you want more information about us, call the Plan's Customer Service Center on Oahu at 808/432-5955, or on Kauai, Maui or Hawaii at 800/966-5955 or 808/432-7032 TTD, or write to the Health Plan office at 711 Kapiolani Blvd., Tower Bldg., Suite 400, Honolulu, Hawaii 96813. You may also contact us by fax at 808/432-5300 or visit our website at http://www.kaiserpermanente.org/hawaii.

Service Area

To enroll in this Plan, you must live in our service area. This is where our providers practice. Our service area is:

The Islands of Oahu, Kauai, Maui
The Island of Hawaii (except zip codes 96718, 96772, and 96777).

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described on page 46; and for emergency care obtained from any non-Plan provider, as described on page 37. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We removed the requirement that services must be needed to restore functional speech from the speech therapy benefit.

Changes to this Plan

- Your share of the non-Postal premium will decrease by 7% for Self Only or increase 2.3% for Self and Family under the High Option and will increase by 2.7% for Self Only or 2.7% for Self and Family under the Standard Option.
- We provide injectable travel immunizations for adults and children at 50% of our allowance for both High and Standard Options.
- We provide up to 20 combined visits of chiropractic and acupuncture services at $10 per office visit for High Option and $15 per office visit for Standard Option.
- We provide chiropractic appliances up to $50 per calendar year, for both High and Standard Options.
- We provide Traditional Chinese Herbal Supplements at $5 per bottle up to $200 per member for both High and Standard Options.
- We provide outpatient hospital or ambulatory surgical center services at $10 per surgery for High Option and $15 per surgery for Standard Option.
- We provide emergency services within our service area at $25 per visit for both High and Standard Options.
- We provide diabetes equipment (and supplies to operate the equipment) at 50% of our allowance for both High and Standard Options. Control solutions now require a 50% copay, rather than the $7 per prescription copay.
- We provide oral travel immunizations for adults and children at $7 per prescription for both High and Standard Options.
- A travel assistance benefit has been added that will provide you with assistance in locating hospitals, physicians, and other health care providers that would be responsive to your medical needs while you travel.
- We clarified the Preventive care, adult benefit by removing the entry for blood lead level testing for adults because it is a test more typically done for children.
- If you have Medicare Part B benefits, we now require that you assign your Medicare Part B benefits to the Plan to receive covered services.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We changed the address for sending disputed claims to OPM.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui or Hawaii.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and coinsurance. You will not have to file claims, except for emergency, urgent care services outside our service area and for covered services while you travel.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We contract with the Hawaii Permanente Medical Group, an independent multi-specialty group of physicians ("Plan physicians"), to provide or arrange all necessary physician care for you. These physicians are members of American Specialty Boards or are Board eligible. Your medical care is provided through physicians, nurse practitioners, physician assistants, and other skilled medical personnel working as medical teams at our facilities. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. Services such as physical therapy, laboratory, and X-ray services are available to you at our facilities. Plan physicians can also arrange any necessary specialty care for you. Hospital care is provided to you through the Kaiser Permanente Moanalua Medical Center on Oahu and several local community hospitals on the Neighbor Islands. Dental services are provided by Hawaii Dental Service.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at www.kaiserpermanente.org/hawaii.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We offer comprehensive health care at 23 Plan facilities conveniently located on the Islands of Oahu, Kauai, Maui and Hawaii; and through specialists, hospitals and other providers in the community following an authorized referral.

We list Plan facilities in our provider directory, which we update periodically. The list is also on our website at www.kaiserpermanente.org/hawaii.

You must receive your health care services at Plan facilities, except if you have an emergency. If you are visiting another Kaiser Permanente service area, you may receive health care services from those Kaiser Permanente facilities. Your travel benefit allows you to receive follow-up or continuing care while you travel anywhere.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

Choose your primary care physician from this Plan's provider directory. It lists Plan facilities and services available at each facility with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Customer Service Center on Oahu at 808/432-5955, or on Kauai, Maui, or Hawaii at 800/966-5955.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care and will obtain the necessary authorization. The referral will describe the services you will receive. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. If your specialist recommends additional visits or services, your primary care physician will review the recommendation and authorize the visits or services, as appropriate. Do not go to the specialist for return visits unless your primary care physician and Plan gives you a referral. A woman may see her gynecologist without a referral. You may also receive vision care and mental health and substance abuse services without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will arrange for you to see your specialist. Your specialist will develop a treatment plan for a certain number of visits without additional referrals.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

— terminate our contract with your specialist for other than cause; or

— drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or

— reduce our service area and you enroll in another FEHB plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Center immediately at 808/432-5955 on Oahu, or on Kauai, Maui, or Hawaii at 800/966-5955. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior authorization. Your physician must obtain approval for services which include, but are not limited to: transplants, in vitro fertilization, hospice, referrals to facilities outside of Hawaii, air ambulance to facilities outside of Hawaii, and care delivered by a non-Plan physician.

Requests for these services are made to your primary care physician just like any other referral. Your primary care physician submits the request, with supporting documentation. If your request is not approved, you have a right to appeal by calling 808/432-5955 on Oahu or 800/966-5955 on Kauai, Maui, or Hawaii. If you wish additional services, you must make the request to your primary care physician.

Emergency services do not require prior authorization. However, you or your family member must notify the Plan within 48 hours, or as soon as is reasonably possible or your claim may be denied.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

  A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician, you pay a copayment of $10 (High Option) or $15 (Standard Option) per office visit.

- **Deductible**

  We do not have a deductible.

  NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

  And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

- **Coinsurance**

  Coinsurance is the percentage of our allowance that you must pay for certain services you receive. Example: In our Plan, you pay 20% of our allowance for in vitro fertilization.

- **Fees when you fail to make your copayment or coinsurance**

  If you do not pay your copayment or coinsurance at the time you receive services, we will bill you. You will be required to pay a $15 charge for each bill sent for unpaid services.

Your catastrophic protection out-of-pocket maximum for copayments and coinsurance

After your copayments and coinsurance total $1,000 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Drugs and contraceptive devices
- Diabetes equipment and supplies to operate the equipment
- Dental services
- Blood
- $25 charges paid for follow-up or continuing care
- Any non-FEHB benefits

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits - OVERVIEW

(See page 9 for how our benefits changed this year and pages 68 and 69 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui, or Hawaii or at our website at http://www.kaiserpermanente.org/hawaii.

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • Note: You pay only $5 under our Standard Option and we waive the $10 charge under our High Option if you enroll in our Medicare+Choice Plan and assign your Medicare benefits to the Plan.	IMPORTANT

Benefit Description	You pay	
Diagnostic and treatment services	**You pay - Standard Option**	**You pay - High Option**
Professional services of physicians and other health care professionals • In a physician's medical office • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • In an urgent care center	$15 per office visit	$10 per office visit
• During a hospital stay • In a skilled nursing facility (up to 100 days per benefit period)	Nothing	Nothing
Not covered: • *House calls by physicians*	*All charges*	*All charges*

Lab, X-ray, and other diagnostic tests	You pay - Standard Option	You pay - High Option
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound • Electrocardiogram and EEG	50% of charges	Nothing
Preventive care, adult		
Routine screenings, such as: • Total blood cholesterol • Fecal occult blood test • Prostate Specific Antigen (PSA test) - one annually for men age 40 and older • Routine pap test Note: You should consult with your physician to determine what is appropriate for you. Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	50% of charges	Nothing
• Colorectal cancer screening, including — sigmoidoscopy screening - every five years starting at age 50 Note: You should consult with your physician to determine what is appropriate for you.	$15 per office visit	$10 per office visit

Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing	Nothing
Injectable travel immunizations Note: You will also pay the office visit copayment when you receive your immunization. Note: We cover oral travel immunizations under the prescription drug benefit.	50% of our allowance	50% of our allowance
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Attending schools* • *Travel*	*All charges*	*All charges*
Preventive care, children	**You pay - Standard Option**	**You pay - High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Examinations, such as: — Eye exams through age 17 to determine the need for vision correction — Ear exams through age 17 to determine the need for hearing correction —Examinations done on the day of immunizations (up to age 22) • Well-child care for routine examinations up to age 22	$15 per office visit	$10 per office visit

Injectable travel immunizations Note: You will also pay the office visit copayment when you receive your immunization. Note: We cover oral travel immunizations under the prescription drug benefit.	50% of our allowance	50% of our allowance
Not covered: *Physical exams required for:* • *Obtaining or continuing employment* • *Insurance* • *Attending schools and camp* • *Travel*	*All charges*	*All charges*
Maternity care	**You pay - Standard Option**	**You pay - High Option**
After confirmation of pregnancy, complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury, see page 34 for hospital benefits and page 29 for surgery benefits.	Nothing	Nothing
Not covered: • *Routine sonograms to determine fetal age, size, or sex*	*All charges*	*All charges*

Family planning	You pay - Standard Option	You pay - High Option
A broad range of voluntary family planning services, limited to: • Family planning services, including counseling • Voluntary sterilization • Surgically implanting contraceptives • Injection of contraceptive drugs • Insertion of intrauterine devices (IUDs) Note: We cover contraceptive drugs and devices under the prescription drug benefit.	$15 per office visit	$10 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services		
Diagnosis and treatment of involuntary infertility, such as: • Artificial insemination: —Intravaginal insemination (IVI) —Intracervical insemination (ICI) —Intrauterine insemination (IUI)	$15 per office visit	$10 per office visit
One in vitro fertilization (IVF) procedure per lifetime (for females who qualify under Hawaii law) Note: We cover drugs used to treat involuntary infertility and in vitro fertilization under the prescription drug benefit, and laboratory tests under the laboratory benefit.	20% of charges	20% of charges

Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Assisted reproductive technology (ART) procedures, such as embryo transfer, GIFT, and ZIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm and donor egg and services related to their procurement, processing, and storage* • *Infertility service when either member of the family has been voluntarily sterilized*	*All charges*	*All charges*
Allergy care	**You pay - Standard Option**	**You pay - High Option**
• Testing and treatment • Allergy injection	$15 per office visit	$10 per office visit
Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies		
• Chemotherapy and radiation therapy Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/Tissue Transplants. • Respiratory and inhalation therapy • Dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We cover GHT drugs under the prescription drug benefit.	$15 per office visit	$10 per office visit
Not covered: • *Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered*	*All charges*	*All charges*

Physical and occupational therapies	You pay - Standard Option	You pay - High Option
Up to two consecutive months of therapy per condition if significant improvement can be expected within that period: • Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury • Occupational therapy by occupational therapists to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life	$15 per outpatient visit Nothing for inpatient	$10 per outpatient visit Nothing for inpatient
Not covered: • *Long-term physical therapy or occupational therapy* • *Exercise programs* • *Cardiac rehabilitation* • *Occupational therapy supplies*	*All charges*	*All charges*
Speech therapy		
Up to two consecutive months of therapy per condition: • Speech therapy by speech therapists when medically necessary	$15 per outpatient visit Nothing for inpatient	$10 per outpatient visit Nothing for inpatient
Not covered: *Speech therapy that is not medically necessary such as:* • *Therapy for educational placement or other educational purposes* • *Training to improve fluency or modify dialect* • *Voice therapy for occupation or performing arts* • *Therapy supplies*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)		
• Hearing testing for adults to determine the need for hearing correction • Hearing testing for children through age 17	$15 per office visit	$10 per office visit

Not covered: • *Hearing aids, testing, and examinations for them* • *All other hearing testing*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**You pay - Standard Option**	**You pay - High Option**
• Diagnosis and treatment of diseases of the eye • Eye exam for children to determine the need for vision correction through age 17 (see page 18, Preventive care, children) • Eye refractions (for a written lens prescription for eyeglasses, but not for contact lenses)	$15 per office visit	$10 per office visit
Not covered: • *Eyeglasses* • *Contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery such as lasik*	*All charges*	*All charges*
Foot care		
No benefit, except for diabetes	*All charges*	*All charges*
Orthopedic and prosthetic devices		
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: We cover surgery necessary to insert the device.	Nothing	Nothing

Not covered: • *Comfort, convenience, or luxury equipment or features* • *Orthopedic devices and corrective shoes* • *Braces and splints* • *Durable medical equipment* • *External prosthetic devices, except as listed above* • *Prosthetic devices and supplies related to sexual dysfunction* • *Arch supports* • *Foot orthotics* • *Take home items* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*	*All charges*
Durable medical equipment (DME)	**You pay - Standard Option**	**You pay - High Option**
• Glucose meter (and control solutions) • External insulin pump • Supplies necessary to operate these items Note: These items are covered only when obtained through sources designated by the Plan	50% of our allowance	50% of our allowance
Not covered: *All other durable medical equipment*	*All charges*	*All charges*

Home health services	You pay - Standard Option	You pay - High Option
Services ordered by a physician to homebound members residing in the service area: • Nursing • Physical therapy, speech therapy, occupational therapy • Medical social services and home health aide when related to physical therapy, speech therapy, or occupational therapy • Medical supplies included in the plan of care Note: We cover IV therapy and medications under the prescription drug benefit.	$15 per visit	$10 per visit
Not covered: • *Nursing care requested by you or your family for you or your family's convenience* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Care that your physician determines can be appropriately provided in the medical office, hospital, or skilled nursing facility* • *Prosthetics, durable medical equipment, supplies, and drugs (not part of home infusion program)* • *Personal care items* • *Services outside our service areas*	*All charges*	*All charges*
Chiropractic		
Up to a maximum of 20 combined chiropractic and acupuncture visits per calendar year: • Chiropractic services for the treatment or diagnosis of neuromusculo-skeletal disorders • Adjunctive therapy as set forth in a treatment plan approved by the ASHN • X-rays Note: Services must be performed by and received from Participating Chiropractors of American Specialty Health Networks™ (ASHN). Contact Kaiser Permanente Customer Service at 808/432-5955 on Oahu, and 800/966-5955 on Neighbor Islands.	$15 per office visit	$10 per office visit

Chiropractic appliances when prescribed by a participating chiropractor and authorized by ASHN. Note: **We pay no more than $50 per calendar year.** When the $50 maximum is reached, the Member must pay the full retail price for all chiropractic appliances for the remainder of the calendar year.	All charges over $50	All charges over $50
Not covered: • *Any services or treatment not authorized by ASHN, except for an initial examination* • *Services related to the chiropractic treatment that is performed or prescribed by a Plan physician*	*All charges*	*All charges*
Alternative treatments	**You pay - Standard Option**	**You pay - High Option**
Up to a maximum of 20 combined chiropractic and acupuncture visits per calendar year: • Acupuncture services for the treatment or diagnosis of neuromusculo-skeletal disorders, nausea or pain syndromes • Adjunctive therapy as set forth in a treatment plan approved by the ASHN Note: Services must be performed by and received from Participating Acupuncturists of American Specialty Health Networks™ (ASHN). Contact Kaiser Permanente Customer Service at 808/432-5955 on Oahu, and 800/966-5955 on Neighbor Islands.	$15 per office visit	$10 per office visit
Traditional Chinese Herbal Supplements (TCHS) which are recommended by a participating acupuncturist, authorized by ASHN, and are distributed through the ASHN mail order distribution program. Note: There is a $200 maximum which is based upon the full retail price of the TCHS less the $5 copayment. When the $200 maximum is reached, the Member must pay the full retail price for the TCHS for the remainder of the calendar year.	$5 per bottle, or All charges after we have paid the $200 coverage maximum	$5 per bottle, or All charges after we have paid the $200 coverage maximum

Not covered: • *Any services or treatment not authorized by ASHN, except for an initial examination* • *Services related to the acupuncture treatment that is performed or prescribed by a Plan physician* • *Other alternative treatments such as naturopathic services, hypnotherapy, and biofeedback* • *All other forms of alternative treatment*	*All charges*	*All charges*
Educational classes and programs	**You pay - Standard Option**	**You pay - High Option**
Our Health Education Department and Lifestyle Program offers a wide variety of classes to members and the public. Participants can learn how to take charge of their own health and well-being, manage their chronic conditions, give up unhealthy habits, and make positive, health enhancing changes in their lifestyle.		
Patient education classes, such as: • Cholesterol Classes • Living and Learning with Diabetes • Osteoporosis Group Education Clinic • Quit Smoking Program	$15 per visit	$10 per visit
Lifestyle and health promotion classes, such as: • Body Conditioning • Iyengar Yoga • Prenatal/Post-Partum Exercise • 55 Alive Mature Driving • Heart Saver (Basic CPR-Course A) • Childbirth Preparation/Lamaze Class • Couples Communication I • Parenting Patterns Workshop • Shapedown	Class fee varies from $10 to $85	Class fee varies from $10 to $85

Other classes (including support groups) such as: • Menopausal Years • Breastfeeding Your Baby • Mothers Share Group • New Sibling Class/Tour • Arthritis Support Group • H.O.P.I.N.G. (Helping Other Parents In Normal Grieving) • Stroke Club	Nothing	Nothing
Smoking Cessation Program Our nicotine dependence/smoking cessation program offers self-help information, group appointments, telephone counseling and support, and monthly sessions. You must complete our smoking cessation class to have your nicotine replacement therapy medications covered under the Prescription drug benefit.	$15 per class	$10 per class

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the pre-authorization information shown in Section 3 to be sure which services require pre-authorization and identify which surgeries require pre-authorization.

IMPORTANT

Benefit Description	You pay	
Surgical procedures	**You pay - Standard Option**	**You pay - High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Pre-surgical testing • Correction of amblyopia and strabismus • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices • Voluntary sterilization (tubal ligation or vasectomy) • Insertion of Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). Note: We cover surgically implanted contraceptives and intrauterine devices under the prescription drug benefit. • Treatment of burns	$15 per office visit for outpatient services Nothing for inpatient services	$10 per office visit for outpatient services Nothing for inpatient services

Surgical procedures	You pay - Standard Option	You pay - High Option
• Endoscopy procedures • Biopsy procedures	50% of charges	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot*	*All charges*	*All charges*
Reconstructive surgery		
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: —the condition produced a major effect on the member's appearance; and — the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: —surgery to produce a symmetrical appearance on the other breast; —treatment of any physical complications, such as lymphedemas; and —breast prostheses and surgical bras and replacements (see Prosthetic devices). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$15 per office visit for outpatient services Nothing for inpatient services	$10 per office visit for outpatient services Nothing for inpatient services
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, and which will not result in significant improvement in physical function* • *Surgeries related to sex transformation*	*All charges*	*All charges*

Oral and maxillofacial surgery	You pay - Standard Option	You pay - High Option
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	$15 per office visit for outpatient services Nothing for inpatient services	$10 per office visit for outpatient services Nothing for inpatient services
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes* • *Correction of malloclusion* • *Any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*	*All charges*

Organ/tissue transplants	You pay - Standard Option	You pay - High Option
Limited to: • Cornea • Heart • Heart/lung • Kidney • Simultaneous pancreas-kidney • Liver • Lung: Single –Double • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Note: We cover directly related medical and hospital expenses of the donor when we cover your transplant.	$15 per office visit for outpatient services Nothing for inpatient services	$10 per office visit for outpatient services Nothing for inpatient services
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of non-human or artificial organs* • *Transplants not listed as covered* • *Transportation, lodging, and living expenses*	*All charges*	*All charges*
Anesthesia		
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Office	Nothing	Nothing

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).

IMPORTANT

Benefit Description	You pay	
Inpatient hospital	**You pay - Standard Option**	**You pay - High Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: Your physician may prescribe private accommodations or private duty nursing care if it is medically necessary. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	10% of daily room rate charges	Nothing

Inpatient hospital	You pay - Standard Option	You pay - High Option
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Dressings, casts, and sterile trays • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Administration of blood and blood products Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The conditions for which we will provide hospitalization include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition. We do not cover dental procedures	Nothing	Nothing
• Diagnostic laboratory tests and X-rays	50% of charges	Nothing
• Blood, limited to whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin • Collection, storage, and processing of autologous blood for covered scheduled surgery whether or not the units are used	20% of charges	20% of charges
Not covered: • *Donor directed units of blood* • *Custodial care* • *Non-covered facilities* • *Personal comfort items, such as telephone, television, barber services, guest meals, and beds* • *Take home items* • *Private nursing care* • *Any inpatient dental procedures*	*All charges*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay - Standard Option	You pay - High Option
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Dressings, casts, and sterile trays • Medical supplies, including oxygen • Anesthetics and anesthesia service • Administration of blood and blood products • Pre-surgical testing	$15 per surgery	$10 per surgery
• Diagnostic laboratory tests, X-rays, and pathology services	50% of charges	Nothing
• Blood, limited to whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin • Collection, storage and processing of autologous blood for covered scheduled surgery whether or not the units are used	20% of charges	20% of charges
Not covered: • *Donor directed units of blood*	*All charges*	*All charges*
Extended care benefits/skilled nursing care facility benefits		
Up to 100 days per benefit period when full time care is necessary. A benefit period begins when you enter a hospital or skilled nursing facility and ends when you are not a patient in either a hospital or skilled nursing facility for 60 consecutive days. Services include: • Nursing care • Bed and board • Physical, occupational, and speech therapy • Medical social services • Prescribed drugs • Medical supplies	Nothing	Nothing

Not covered: • *Custodial care* • *Personal comfort items, such as telephone, television, barber services, guest meals, and beds*	*All charges*	*All charges*
Hospice care	**You pay - Standard Option**	**You pay - High Option**
If you are diagnosed with a terminal illness with a life expectancy of six months or less, you may elect hospice care. Hospice care is supportive and palliative care (including family counseling) for a terminally ill member when provided by a Plan approved licensed hospice. Short-term inpatient care is limited to respite care, care for pain control, and acute and chronic symptom management. Note: Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.	Nothing	Nothing
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*	*All charges*
Ambulance		
• Local professional ambulance service when medically appropriate	20% of charges	20% of charges
Not covered: • *Transports that we determine are not medically necessary*	*All charges*	*All charges*

Section 5 (d). Emergency services/accidents

	IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure, and we cover them only when we determine they are medically necessary. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • We have no calendar year deductible.	IMPORTANT	

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a life-threatening emergency, call 911. When the operator answers, stay on the phone and answer all questions.

Emergencies within our service area:

Emergency care is provided at Plan hospitals 24 hours a day, seven day a week. If you reasonably believe you have a medical emergency condition and you cannot safely go to a Plan Hospital, call 911 or go to the nearest hospital. If an ambulance comes, tell the paramedics that the person who needs help is a Kaiser Permanente member.

If you are admitted to a non-Plan facility, you or your family member must notify us within 48 hours, or as soon as reasonably possible by calling the phone number on the back of your Kaiser Permanente membership card. This must be done, or your claim for payment may be denied. We may arrange for your transfer to a Plan facility as soon as it is medically appropriate to do so.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan facility would result in death, disability, or significant jeopardy to your condition. After an emergency in the service area, follow-up and continuing care at a non-Plan facility are not covered.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of a sudden or unforeseen injury or illness.

If you need to be hospitalized, the Plan must be notified within 48 hours, or as soon as reasonably possible. If a Plan physician believes care can be better provided in a Plan hospital, we will transfer you when medically feasible.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under Kaiser Permanente. You may also obtain information about the location of facilities by calling the Customer Service Center at 800/966-5955.

Benefit Description	You pay	
Emergency within our service area	**You pay - Standard Option**	**You pay - High Option**
• Emergency care at a physician's office • Emergency care at an urgent care center • Emergency care at a hospital, including physicians' services	$25 per visit	$25 per visit
Not covered: • *Elective care or non-emergency care*	*All charges*	*All charges*
Emergency outside our service area		
At a non-Plan facility: • Emergency care at a physician's office • Emergency care at an urgent care center • Emergency care at a hospital, including physicians' services	20% of our allowance plus any additional charges which would be required if you received your care from the Plan	20% of our allowance plus any additional charges which would be required if you received your care from the Plan
At a Plan facility: • Emergency care in a Kaiser Foundation Hospital in another Kaiser Foundation Health Plan service area Note: We cover continuing or follow-up care under the Travel Benefit.	The amount you would be charged if you were a member in that service area	The amount you would be charged if you were a member in that service area
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance		
Professional ambulance service (including air ambulance) when medically appropriate. Note: For non-emergency service, see page 36.	20% of charges	20% of charges
Not covered: • *Transports we determine are not medically necessary*	*All charges*	*All charges*

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT	When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions. **Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure, and we cover them only when we determine they are clinically appropriate to treat your condition. • Plan physicians must provide or arrange for your care. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

Benefit Description	You pay	
Mental health and substance abuse benefits	**You pay - Standard Option**	**You pay - High Option**
We cover all diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan. The treatment plan may include services, drugs and supplies described elsewhere in this brochure. Note: We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a Plan provider. Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another.	Your cost sharing responsibilities are no greater than for other illnesses or conditions	Your cost sharing responsibilities are no greater than for other illnesses or conditions

Mental health and substance abuse benefits	You pay - Standard Option	You pay - High Option
Diagnosis and treatment of psychiatric conditions, mental illness, or disorders of children, adolescents, and adults. Outpatient services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Psychological testing necessary to determine appropriate psychiatric treatment • Psychiatric treatment (including individual and group therapy visits) • Medication evaluation and management Diagnosis and treatment of alcoholism and drug abuse. Outpatient services include: • Detoxification (the withdrawal process from physically-addictive drugs and/or alcohol when withdrawal is likely to cause medical or life-threatening complications) • Treatment and counseling (including individual and group therapy visits) Note: You may see a Plan outpatient mental health or substance abuse provider without a referral from your primary care physician. Note: Your Plan provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.	$15 per office visit	$10 per office visit
• Inpatient psychiatric or substance abuse care • Hospital alternative services, such as partial hospitalization, day treatment, and intensive outpatient psychiatric treatment programs • Day treatment programs for substance abuse Note: All inpatient admissions, hospital alternative services, and day treatment programs require approval by a Plan physician.	10% of daily room charges	Nothing

Mental health and substance abuse benefits	You pay - Standard Option	You pay - High Option
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state, or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*	*All charges*

Limitation We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

	IMPORTANT	**Here are some important things to keep in mind about these benefits:** • We cover prescribed drugs and medications, as described in the chart beginning on the next page. • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are clinically appropriate to treat your condition. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • We have no calendar year deductible.	IMPORTANT	

There are important features you should be aware of. These include:

- **Who can write your prescription.** A Plan physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription and receive refills at a Plan pharmacy. The only drugs available through mail order are maintenance drugs.

  Obtain mail order prescription forms at any Plan pharmacy, or call the Plan's mail order pharmacy at 808/432-5510, Monday - Friday, 8:30 A.M. to 5:00 P.M. You may purchase drugs through the Plan's mail order prescription service. Please mail your refill order before you are down to your last 10 days supply. Allow one week to receive your medication for refillable orders. We do not deliver the following drugs through mail order: narcotics, tranquilizers, bulky items, injectables, and medication affected by temperature.
- **We use a formulary.** A formulary is a listing of preferred pharmaceutical substances and formulas. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. These preferred drugs are included on our formulary. We use a formulary to determine which drugs to prescribe to you. If the physician specifically prescribes a nonformulary drug because it is medically necessary, the nonformulary drug will be covered.

  When generic substitution is permissible (i.e. a generic drug is available and the prescribing physician does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and the name brand drug, as well as the $7 charge per prescription unit or refill.
- **There are dispensing limitations.** We provide up to a 30-day supply and one cycle of a contraceptive drug.
- **When you have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

Prescription drug benefits begin on the next page.

Benefit Description	You pay	
Covered medications and supplies	**You pay - Standard Option**	**You pay - High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that require a physician's prescription • Disposable needles and syringes for the administration of covered medications • Diabetes supplies limited to glucose strips, lancets, and insulin syringes • Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU) • Oral immunosuppressive drugs required after a transplant • Oral travel immunizations • Smoking cessation drugs, including nicotine patches. Coverage is limited to one course of treatment per calendar year, if: —the drug is prescribed by a Plan physician; and —the member enrolls in and pays the fees for a Plan approved smoking cessation program • Insulin	$7 per prescription	$7 per prescription
• Contraceptives —Oral Contraceptives	$7 per cycle	$7 per cycle
—Diaphragms —Cervical caps	$7 each	$7 each
—Injectable contraceptive drugs (such as Depo-Provera)	$7 times the expected number of months the medication will be effective	$7 times the expected number of months the medication will be effective

Covered medications and supplies	You pay - Standard Option	You pay - High Option
—Intrauterine devices (IUD's) —Implanted time release contraceptive drugs (such as Norplant) Note: We will not refund any portion of the copayment if the IUD is removed or spontaneously expulsed, or the implanted time release drug is removed before the end of its lifetime.	$7 times the expected number of months the medication or device will be effective, not to exceed $250	$7 times the expected number of months the medication or device will be effective, not to exceed $250
• Drugs to treat sexual dysfunction have dispensing limitations. Contact the Plan for details.	50% of charges	50% of charges
Not covered: • *Drugs related to non-covered services* • *Drugs obtained at a non-Plan pharmacy, except as part of a covered out-of-area emergency* • *Drugs to enhance athletic performance* • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional supplements that can be purchased without a prescription* • *Nonprescription drugs* • *Medical supplies (such as dressings and antiseptics), except as listed above*	*All charges*	*All charges*

Section 5 (g). Special features

Feature	Description
Services from other Kaiser Permanente Plans	When you visit the service area of another Kaiser Permanente plan, you are entitled to receive virtually all the benefits described in this brochure at any Kaiser Permanente medical office or medical center. You will have to pay the copayments or other charges imposed by the Plan you are visiting. If the Plan you are visiting has a benefit that differs from the benefits of this Plan, you are not entitled to receive that benefit. Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be covered if you receive them in other Kaiser Permanente service areas. If a benefit is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by this Plan. If you are seeking routine, non-emergent, or non-urgent services, you should call your Plan facility in that service area and request an appointment. You may obtain routine follow-up or continuing care from these Plans, even when you have obtained the original services in our service area. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care. At the time you register for services, you will be asked to pay the charges required by the local Plan. If you wish to obtain more information about the benefits available to you from a Kaiser Permanente Plan in an area you visit, please call our Customer Service Center at 808/432-5955 on Oahu, or on Kauai, Maui, or Hawaii at 800/966-5955.
Interpretive services	If you need interpretive services during your visit, please ask an English-speaking friend or relative to call our Customer Service Center at 808/432-5955 on Oahu or 800/966-5955 on neighbor islands.
24 hour advice line	For any of your health concerns, you may talk with a registered nurse 24 hours a day, 7 days a week, who will discuss your treatment options and answer your health questions. During clinic hours, you may call your clinic. During after hours, you may call 808/432-7700 on Oahu or 800/467-3011 on the other islands. Hours of operation are: • Monday through Friday, 5 p.m. – 8 a.m. • Noon, Saturday, through 8 a.m., Monday • Holidays, all day

Travel benefit	Kaiser Permanente's travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for covered services for conditions diagnosed by a Kaiser Permanente health care provider or affiliated Plan provider that have been treated within the previous 90 days. Services include childhood immunizations, dialysis, or prescription drug monitoring. • You pay $25 for each follow-up or continuing care office visit. We deduct this amount from the payment we make to you. • We pay no more than $1200 each calendar year. • For more information about this benefit call the Travel Benefit Information Line at 800/390-3509. Claims should be submitted to Affiliated Care, Kaiser Foundation Health Plan, Inc., 80 Mahalani Street, Wailuku, Hawaii 96793. *The following are not included in your travel benefits coverage:* • *Non-emergency hospitalization* • *Infertility treatments* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *Transplants* • *Prescription drugs*

Travel assistance	In addition to the Kaiser Permanente travel benefit stated above, the Plan will provide travel and medical assistance for Federal members traveling domestically and abroad. Services and products to assure access to appropriate health care services and travel assistance while away from home include: • Pre-trip information • Precertification assistance for inpatient hospital stays • Case management assistance • Translation services • Provider location assistance • Medical transport assistance • Emergency medication assistance • Lost document assistance • Emergency messaging • Lost baggage assistance The cost for uninsured services will be paid by the member including but not limited to: transportation costs, assistance for unattended minors, repatriation of remains, lost document costs, and medical evacuation. Members who need assistance should contact World Access. If members are travelling: • within the United States, Puerto Rico and the Virgin Islands, call toll free at 1-866-221-7870; • worldwide (outside US, Puerto Rico or Virgin Islands), call collect at 804-673-1497. Both numbers are available 24 hours a day, 365 days a year.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we pay them only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure unless it is described below.

IMPORTANT

Accidental injury benefit	You pay - Standard Option	You pay - High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Any other services are provided as described below.	$15 per office visit	$10 per office visit

Dental benefits

We cover dental benefits. You may choose your dentist and your out-of-pocket expenses will be based on your dentist's eligible fees and your plan benefits. During your first appointment, advise your dentist that you are covered by the Kaiser Foundation Health Plan Federal Dental Care Program, and present your Hawaii Dental Service (HDS) member identification card to your dentist.

If your dentist must perform procedures totaling $400 or more, your dentist must submit a claim form to HDS before providing services to you. Upon HDS's approval, your dentist should explain your treatment plan, the dollar amount your dental benefits plan will cover, and the amount you will pay before performing the services.

Before you receive treatment, you should discuss the total charges and your financial obligations with your dentist. You are financially responsible for any remaining balance between your dentist's eligible fee and the HDS payment.

Service	You pay - Standard Option	You pay - High Option
We cover diagnostic and preventive care services when provided through Hawaii Dental Service: • Examinations – once every calendar year • Bitewing X-rays – twice every calendar year	Nothing	Nothing
• Other X-rays – limited to one full mouth series of X-rays (including bitewings) once every three years • Prophylaxis (cleaning) – once every calendar year • Stannous fluoride – once every calendar year and for dependent children only • Palliative treatment – for relief of pain	20% of our allowance	20% of our allowance

Service	You pay - Standard Option	You pay - High Option
Not covered: • *Cosmetic dental services* • *Prosthodontic services or devices (including crowns and bridges) started prior to the date you became eligible under this Program* • *Orthodontic services* • *Dental services not listed as covered*	*All charges*	*All charges*

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan physician determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Section 5(d)), services under the Travel Benefit (see Section 5(g)), and services received from other Kaiser Permanente plans (see Section 5(g));
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 808/243-6610 on Maui or 877/975-3805 on all other islands.

When you must file a claim – such as for out-of-area care – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Affiliated Care - Claims Department
Kaiser Foundation Health Plan, Inc.
80 Mahalani Street
Wailuku, HI 96793

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

If you have a malpractice claim

If you have a malpractice claim because of services you did receive, or did not receive, from a Plan provider, you must submit the claim to binding arbitration. The Plan has the information that describes the arbitration process. Contact our Customer Service Center on Oahu at 808/432-5955, or on Kauai, Maui, or Hawaii at 800/966-5955 for copies of our requirements. These will explain how you can begin the binding arbitration process.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for pre-authorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Regional Appeals Coordinator, Affiliated Care, Kaiser Foundation Health Plan, Inc., 501 Alakawa Street, Honolulu, HI 96817; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, D.C. 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at the Expedited Review Hotline at 866/233-2851 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payer, and you received your services from Plan providers, we may bill the primary carrier.

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.

- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. We will not waive any of our copayments.

(Primary payer chart begins on next page.)

The following chart illustrates whether **Original Medicare** Plan or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you – or your covered spouse – are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)		✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation)	
B. When you – or a covered family member – have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

• Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we waive or lower some of our copayments and coinsurance for your FEHB and Medicare coverage. If you would like information about our Medicare+Choice plan, please call 808/432-2010 in Oahu and 800/564-2010 on Neighbor Islands. Your Kaiser Permanente Senior Advantage-FEHBP benefits that we lowered or waived are:

High Option

- Office visits: $0 for physicians and other health professionals visits
- Emergency care: $25 for each emergency visit
- Preventive services visits: $0
- Routine physical and hearing exams: $0 for each routine physical and hearing exam
- Immunizations: Pneumoccoccal pneumonia, flu, and hepatitis B vaccines at no charge
- Urgently needed care: $0 for each visit to a Plan facility
- One routine eye exam each year: $0
- Durable medical equipment: 20% copayment
- External prosthetics: 20% copayment
- Blood, blood transfusions, and blood products: $0
- Dialysis: $0
- Routine foot care: $0
- Manual manipulation of the spine to correct subluxation: $0
- Intraocular lens after cataract surgery: 20% copayment

Standard Option

- Office visits: $5 copayment for physicians and other health professionals visits
- Lab, X-ray, and diagnostic services: $0
- Emergency care: $25 for each emergency visit
- Preventive services visits: $5 copayment
- Routine physical and hearing exams: $5 copayment for each routine physical and hearing exam
- Immunizations: Pneumoccoccal pneumonia, flu, and hepatitis B vaccines at no charge
- Urgently needed care: $5 copayment for each visit to a Plan facility
- One routine eye exam each year: $5
- Durable medical equipment: 20% copayment
- External prosthetics: 20% copayment
- Blood, blood transfusions, and blood products: $0
- Dialysis: $0
- Routine foot care: $5 copayment
- Manual manipulation of the spine to correct subluxation: $5 copayment
- Intraocular lens after cataract surgery - 20% copayment

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary if you use our Plan providers, but we will not waive or lower any of our copayments or coinsurance. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care service area.

- **If you enroll in Medicare Part B**

If you enroll in Medicare Part B, we require you to assign your Medicare Part B benefits to the Plan for its services.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B, and if you cannot get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.

Experimental or investigational services

We consider a service, supply or drug to be experimental when the service or supply, including a drug:

(1) has not been approved by the FDA; or
(2) is the subject of a new drug or new device application on file with the FDA; or
(3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or
(4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or
(5) is subject to the approval or review of an Institutional Review Board; or
(6) requires an informed consent that describes the service as experimental or investigational.

We do not cover a service, supply, or drug that we consider experimental.

This Plan and our Medical Group carefully evaluate whether a particular therapy is safe and effective or offers a degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical literature.

Group health coverage

Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

Medically necessary

All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of your receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.

Our allowance

The amount we use to determine your coinsurance. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, we determine the amount that we believe is usual and customary for the service or supply, and compare it to the charges. Our allowance is based upon the reasonableness of the charges. If the charges exceed what we believe is reasonable, you may be responsible for the excess over our allowance in addition to your coinsurance.

Us/We

Us and we refer to Kaiser Foundation Health Plan, Inc., Hawaii Region.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

• Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

  You will receive an additional 31 days of coverage, for no additional premium, when:

  - Your enrollment ends, unless you cancel your enrollment, or
  - You are a family member no longer eligible for coverage.

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **Temporary continuation of coverage (TCC)**

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

• Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB website (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our website at www.opm.gov/insure/ltc.

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Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for Kaiser Foundation Health Plan, Inc. – Hawaii Region – Standard Option – 2002

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$15 per office visit	16
Services provided by a hospital:		
• Inpatient	10% of daily room rate charges	33
• Outpatient	$15 per office visit	35
Emergency benefits:		
• In-area	$25 per visit	38
• Out-of-area	20% or our allowance	38
Mental health and substance abuse treatment:	Regular cost sharing	39
Prescription drugs	$7 per prescription	42
Dental Care	Various copays based on procedure rendered	48
Vision Care	$15 per office visit	23
Special features: Services from other Kaiser Permanente Plans; Interpretive Services; 24 hour advice line; Travel benefit; Travel assistance		45
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,000/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	14

Summary of benefits for Kaiser Foundation Health Plan, Inc. – Hawaii Region – High Option – 2002

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$10 per office visit	16
Services provided by a hospital:		
• Inpatient	Nothing	33
• Outpatient	$10 per office visit	35
Emergency benefits:		
• In-area	$25 per visit	38
• Out-of-area	20% or our allowance	38
Mental health and substance abuse treatment:	Regular cost sharing	39
Prescription drugs	$7 per prescription	42
Dental Care	Various copays based on procedure rendered	48
Vision Care	$10 per visit	23
Special features: Services from other Kaiser Permanente Plans; Interpretive Services; 24 hour advice line; Travel benefit; Travel assistance		45
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,000/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	14

Notes

2002 Rate Information for
Kaiser Foundation Health Plan, Inc., Hawaii Region

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the *FEHB Guide* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the *FEHB Guide for United States Postal Service Employees, RI 70-2.* Different postal rates apply and special FEHB guides are published for Postal Service Nurses, RI 70-2B; and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *FEHB Guide.*

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	631	$91.66	$30.55	$198.59	$66.20	$108.46	$13.75
High Option Self and Family	632	$197.06	$65.69	$426.97	$142.32	$233.19	$29.56
Standard Option Self Only	634	$69.96	$23.32	$151.58	$50.53	$82.79	$10.49
Standard Option Self and Family	635	$150.41	$50.14	$325.90	$108.63	$177.99	$22.56