

# Kaiser Foundation Health Plan, Inc. - Hawaii Region

<http://www.kaiserpermanente.org/hawaii>



KAISER PERMANENTE®

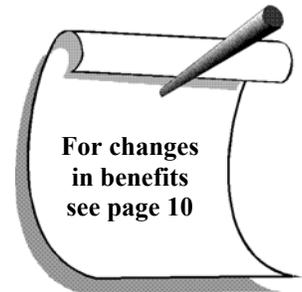
2004

---

## 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 9 for requirements.**



*This Plan has excellent accreditation from the NCQA. See the 2004 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**

Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>



RI 73-005



UNITED STATES  
OFFICE OF PERSONNEL MANAGEMENT  
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on [www.opm.gov/insure!](http://www.opm.gov/insure!)

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at [www.opm.gov](http://www.opm.gov). OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to [www.usajobs.opm.gov](http://www.usajobs.opm.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James  
Director



## Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at [www.opm.gov/insure](http://www.opm.gov/insure) on the web. You may also call 202/606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints  
United States Office of Personnel Management  
P.O. Box 707  
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

---

## Table of Contents

---

Introduction .....	5
Plain Language .....	5
Stop Health Care Fraud! .....	5
Preventing medical mistakes .....	7
Section 1. Facts about this HMO plan .....	8
How we pay providers .....	8
Your Rights.....	8
Service Area.....	9
Section 2. How we change for 2004 .....	10
Program-wide changes.....	10
Changes to this Plan.....	10
Section 3. How you get care .....	11
Identification cards .....	11
Where you get covered care.....	11
• Plan providers.....	11
• Plan facilities .....	11
What you must do to get covered care.....	12
• Primary care .....	12
• Specialty care .....	12
• Hospital care.....	13
Circumstances beyond our control.....	13
Services requiring our prior approval .....	14
Section 4. Your costs for covered services .....	15
• Copayments.....	15
• Deductible .....	15
• Coinsurance.....	15
• Fees when you fail to make your copayment or coinsurance .....	15
Your catastrophic protection out-of-pocket maximum for copayments and coinsurance.....	15
Section 5. Benefits .....	16
Overview.....	16
(a) Medical services and supplies provided by physicians and other health care professionals .....	17
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	29
(c) Services provided by a hospital or other facility, and ambulance services .....	34
(d) Emergency services/accidents.....	39
(e) Mental health and substance abuse benefits.....	41
(f) Prescription drug benefits .....	44

(g) Special features .....	47
• Services from other Kaiser Permanente Plans.....	47
• Interpretive services .....	47
• 24 hour advice line .....	47
• Travel benefit .....	48
• Flexible benefits option .....	48
• Travel assistance.....	49
(h) Dental benefits .....	50
Section 6. General exclusions – things we don't cover .....	52
Section 7. Filing a claim for covered services .....	53
Section 8. The disputed claims process .....	55
Section 9. Coordinating benefits with other coverage .....	57
When you have other health coverage .....	57
• What is Medicare?.....	57
• Should I enroll in Medicare? .....	57
• If you enroll in Medicare Part B.....	58
• The Original Medicare Plan (Part A or Part B).....	58
• Medicare+Choice .....	60
• TRICARE and CHAMPVA .....	61
• Workers' Compensation.....	62
• Medicaid.....	62
• When other Government agencies are responsible for your care .....	62
• When others are responsible for injuries .....	62
Section 10. Definitions of terms we use in this brochure .....	63
Section 11. FEHB facts.....	65
Coverage information .....	65
• No pre-existing condition limitation.....	65
• Where you can get information about enrolling in the FEHB Program .....	65
• Types of coverage available for you and your family .....	65
• Children's Equity Act .....	66
• When benefits and premiums start .....	66
• When you retire.....	66
When you lose benefits.....	66
• When FEHB coverage ends .....	67
• Spouse equity coverage.....	67
• Temporary continuation of coverage (TCC).....	67
• Converting to individual coverage .....	67
• Getting a Certificate of Group Health Plan Coverage.....	68

Two new Federal Programs complement FEHB benefits.....	69
The Federal Flexible Spending Account Program – <i>FSAFEDS</i> .....	69
The Federal Long Term Care Insurance Program.....	73
Index.....	74
Summary of benefits.....	75
Rates .....	Back cover

---

## Introduction

---

This brochure describes the benefits of Kaiser Foundation Health Plan, Inc., Hawaii Region under our contract (CS 1060) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Kaiser Foundation Health Plan, Inc., Hawaii Region's administrative office is:

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

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004, and changes are summarized on page 10. Rates are shown on the back cover of this brochure.

---

## Plain Language

---

All FEHB brochures are written in plain language 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 United States 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](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street NW, Washington, DC 20415-3650.

---

## Stop Health Care Fraud!

---

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

**Protect Yourself From Fraud** – Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 – THE HEALTH CARE FRAUD HOTLINE**  
**202/418-3300**

**OR WRITE TO:**

The United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street, NW, Room 6400  
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

---

## Preventing Medical Mistakes

---

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
  - Ask questions and make sure you understand the answers.
  - Choose a doctor with whom you feel comfortable talking.
  - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
  - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
  - Tell them about any drug allergies you have.
  - Ask about side effects and what to avoid while taking the medicine.
  - Read the label when you get your medicine, including all warnings.
  - Make sure your medicine is what the doctor ordered and know how to use it.
  - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
  - Ask when and how you will get the results of test or procedures.
  - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
  - Call your doctor and ask for your results.
  - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
  - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
  - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
  - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
  - Ask your doctor, "Who will manage my care when I am in the hospital?"
  - Ask your surgeon:
    - Exactly what will you be doing?
    - About how long will it take?
    - What will happen after surgery?
    - How can I expect to feel during recovery?
  - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- [www.ahrq.gov/consumer/pathqpack.htm](http://www.ahrq.gov/consumer/pathqpack.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- [www.talkaboutrx.org/consumer.html](http://www.talkaboutrx.org/consumer.html). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.
- [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's healthcare delivery system.

---

## 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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of our most recent provider directory.

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 or services covered under our travel benefit, 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](http://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
- 46 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 at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui or Hawaii, or 808/643-8833 TTY, 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).

Note: Here are some things to keep in mind:

If you are currently enrolled in, or plan to enroll in, our Senior Advantage plan, the service area requirements may be different from the service area shown above for other federal members.

To enroll in the Senior Advantage plan you must live in the Islands of Oahu, Maui, or the Island of Hawaii (except zip codes 96718, 96772, and 96777).

If you lose eligibility for the Kaiser Permanente Senior Advantage plan because you move outside the Senior Advantage service area, you will no longer be entitled to the enhanced benefits under Section 9 of this brochure.

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. You must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting. See Section 5(g), Special Features, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described on page 48; and for emergency care obtained from any non-Plan provider, as described on page 41. 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 2004

---

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 added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Programs – FSAFEDS and the Federal Long Term Care Insurance Program. See page 69.
- We added information regarding Preventing medical mistakes. See page 7.
- We added information regarding enrolling in Medicare. See page 57.
- We revised the Medicare Primary Payer Chart. See page 59.

### Changes to this Plan

Changes apply to both Standard and High Options unless otherwise noted.

- Your share of the non-Postal premium will increase by 12.5% for Self Only or increase 12.5% for Self and Family under the High Option and will increase by 19.2% for Self Only or 19.1% for Self and Family under the Standard Option.
- Your out-of-pocket maximum increased from \$1,000 per person or \$3,000 per family to \$1,500 per person or \$4,500 per family.
- Your maximum class fee for a lifestyle or health promotion class increased from \$85 to \$93.
- Your class fee for the Bariatric Surgery Program increased from \$800 to \$850.
- For Senior Advantage-FEHB members, your office visits copayment will now be \$10 for the Standard Option for physician and other health professionals visits, preventive services, routine physical and hearing exams, urgently needed care, routine eye exam, and manual manipulation of the spine to correct subluxation.

---

## 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, or write to us at: Kaiser Permanente Customer Service, 711 Kapiolani Boulevard, Honolulu, Hawaii 96813. You may also request replacement cards through our website at <http://www.kaiserpermanente.org/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 Kauai, Maui or Hawaii. Dental services are provided by Hawaii Dental Service.

We list Plan providers in the provider directory, which we update periodically. You may request a copy from our Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui, or Hawaii. The list is also on our website at <http://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 <http://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 at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui, or Hawaii.

### **• 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. If you need further services, you must return to the primary care physician after you receive the services described in the referral. 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 at 800/966-5955 on Kauai, Maui, or Hawaii. 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 92<sup>nd</sup> day after you become a member of this Plan,

whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

**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 want additional services, you must make the request to your primary care physician.

Emergency services do not require prior authorization. However, if you are admitted to a non-Kaiser Permanente facility, 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.
- **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 \$1,500 per person or \$4,500 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 catastrophic protection 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
- Chiropractic and alternative treatments
- \$25 charges paid for follow-up or continuing care outside the service area
- Any non-FEHB benefits

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

---

## Section 5. Benefits - OVERVIEW

*(See page 10 for how our benefits changed this year and page 75 and 76 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 claim 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 [www.kaiserpermanente.org/hawaii](http://www.kaiserpermanente.org/hawaii).

(a) Medical services and supplies provided by physicians and other health care professionals .....	17-28
•Diagnostic and treatment services	•Hearing services (testing, treatment, and supplies)
•Lab, X-ray, and other diagnostic tests	•Vision services (testing, treatment, and supplies)
•Preventive care, adult	•Foot care
•Preventive care, children	•Orthopedic and prosthetic devices
•Maternity care	•Durable medical equipment (DME)
•Family planning	•Home health services
•Infertility services	•Chiropractic
•Allergy care	•Alternative treatments
•Treatment therapies	•Educational classes and programs
•Physical and occupational therapies	
•Speech therapy	
(b) Surgical and anesthesia services provided by physicians and other health care professionals .....	29-33
•Surgical procedures	•Oral and maxillofacial surgery
•Reconstructive surgery	•Organ/tissue transplants
	•Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services .....	34-38
•Inpatient hospital	• Skilled nursing care benefits
•Outpatient hospital or ambulatory surgical center	•Hospice care
	•Ambulance
(d) Emergency services/accidents .....	39-40
•Emergency within our service area	•Ambulance
•Emergency outside our service area	
(e) Mental health and substance abuse benefits .....	41-43
(f) Prescription drug benefits .....	44-46
(g) Special features .....	47-49
•Services from other Kaiser Permanente Plans	•Travel benefit
•Interpretive services	•Flexible benefits option
•24 hour advice line	•Travel assistance
(h) Dental benefits .....	50-51
Summary of benefits .....	75-76

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

<b>I M P O R T A N T</b>	<p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>Plan physicians must provide or arrange your care.</li> <li>We have no calendar year deductible.</li> <li>Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> <li>Note: You pay only \$10 under our Standard Option and \$5 under our High Option if you enroll in our Medicare+Choice Plan and assign your Medicare benefits to the Plan.</li> </ul>	<b>I M P O R T A N T</b>	
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 <ul style="list-style-type: none"> <li>In a medical office</li> <li>Initial examination of a newborn child covered under a family enrollment</li> <li>Office medical consultations</li> <li>Second surgical opinion</li> <li>In an urgent care center</li> </ul>	\$15 per office visit	\$10 per office visit	
<ul style="list-style-type: none"> <li>During a hospital stay</li> <li>In a skilled nursing facility (up to 100 days per benefit period)</li> </ul>	Nothing	Nothing	
<i>Not covered:</i> <ul style="list-style-type: none"> <li><i>House calls by physicians</i></li> </ul>	<i>All charges</i>	<i>All charges</i>	

Lab, X-ray, and other diagnostic tests	You pay - Standard Option	You pay - High Option
<p>Tests, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	50% of our allowance	Nothing
Preventive care, adult		
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Total blood cholesterol</li> <li>• Fecal occult blood test</li> <li>• Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older</li> <li>• Routine pap test</li> </ul> <p>Note: You should consult with your physician to determine what is appropriate for you.</p> <p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> </ul>	50% of our allowance	Nothing
<ul style="list-style-type: none"> <li>• Colorectal cancer screening, including <ul style="list-style-type: none"> <li>— sigmoidoscopy screening - every five years starting at age 50</li> </ul> </li> </ul> <p>Note: You should consult with your physician to determine what is appropriate for you.</p>	\$15 per office visit	\$10 per office visit

*Preventive care, adult -- continued on next page*

<b>Preventive care, adult</b> <i>(continued)</i>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza/Pneumococcal vaccines, annually, age 65 and over</li> </ul>	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
<i>Not covered:</i> <i>Physical exams required for:</i> <ul style="list-style-type: none"> <li>• <i>Obtaining or continuing employment</i></li> <li>• <i>Insurance</i></li> <li>• <i>Attending schools</i></li> <li>• <i>Travel</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Preventive care, children</b>		
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	Nothing	Nothing
<ul style="list-style-type: none"> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>— Eye exams through age 17 to determine the need for vision correction</li> <li>— Ear exams through age 17 to determine the need for hearing correction</li> <li>— Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> <li>• Well-child care for routine examinations up to age 22</li> </ul>	\$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

*Preventive care, children -- continued on next page*

<b>Preventive care, children (continued)</b>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
<p><i>Not covered:</i></p> <p><i>Physical exams required for:</i></p> <ul style="list-style-type: none"> <li>• <i>Obtaining or continuing employment</i></li> <li>• <i>Insurance</i></li> <li>• <i>Attending schools and camp</i></li> <li>• <i>Travel</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Maternity care</b>		
<p>After confirmation of pregnancy, complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery.</li> <li>• 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.</li> <li>• 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.</li> <li>• See Section 5(c), Inpatient hospital for copayments related to room and board for maternity and newborn children</li> <li>• We cover hospitalization and surgical services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgical benefits.</li> </ul>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Routine sonograms to determine fetal age, size, or sex</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

<b>Family planning</b>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Family planning services, including counseling</li> <li>• Voluntary sterilization (See Surgical procedures Section 5(b))</li> <li>• Insertion of surgically implanted time-release contraceptive drugs</li> <li>• Injection of contraceptive drugs</li> <li>• Insertion of intrauterine devices (IUDs)</li> </ul> <p>Note: We cover FDA approved contraceptive drugs and devices under the prescription drug benefit.</p>	\$15 per office visit	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Genetic counseling</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Infertility services</b>		
<p>Diagnosis and treatment of involuntary infertility, such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>—Intravaginal insemination (IVI)</li> <li>—Intracervical insemination (ICI)</li> <li>—Intrauterine insemination (IUI)</li> </ul> </li> </ul>	\$15 per office visit	\$10 per office visit
<p>One in vitro fertilization (IVF) procedure per lifetime (for females who qualify under Hawaii law)</p> <p>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.</p>	20% of our allowance	20% of our allowance

*Infertility services -- continued on next page*

Infertility services <i>(continued)</i>	You pay - Standard Option	You pay - High Option
<p><i>Not covered:</i></p> <p><i>These exclusions apply to fertile as well as infertile individuals or couples:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as embryo transfer, GIFT, and ZIFT</i></li> <li>• <i>Services and supplies related to excluded ART procedures</i></li> <li>• <i>Cost of donor sperm and donor egg and services related to their procurement, processing, and storage</i></li> <li>• <i>Infertility service when either member of the family has been voluntarily sterilized</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Allergy care</b>		
<ul style="list-style-type: none"> <li>• Testing and treatment</li> <li>• Allergy injection</li> </ul>	\$15 per office visit	\$10 per office visit
Allergy serum	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Provocative food testing</i></li> <li>• <i>Sublingual allergy desensitization</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Treatment therapies</b>		
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/Tissue Transplants.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: We cover GHT and chemotherapy drugs under the prescription drug benefit.</p>	\$15 per office visit	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

<b>Physical and occupational therapies</b>	<b>You pay – Standard Option</b>	<b>You pay – High Option</b>
<p>Up to two consecutive months of therapy per condition if significant improvement can be expected within that period:</p> <ul style="list-style-type: none"> <li>• Physical therapy by qualified physical therapists and/or assistants to restore bodily function when you have a total or partial loss of bodily function due to illness or injury</li> <li>• Occupational therapy by occupational therapists and/or assistants to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life</li> </ul>	<p>\$15 per outpatient visit Nothing for inpatient</p>	<p>\$10 per outpatient visit Nothing for inpatient</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term physical therapy or occupational therapy</i></li> <li>• <i>Exercise programs</i></li> <li>• <i>Cardiac rehabilitation</i></li> <li>• <i>Occupational therapy supplies</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Speech therapy</b>		
<p>Up to two consecutive months of therapy per condition:</p> <ul style="list-style-type: none"> <li>• Speech therapy by speech therapists when medically necessary</li> </ul>	<p>\$15 per outpatient visit Nothing for inpatient</p>	<p>\$10 per outpatient visit Nothing for inpatient</p>
<p><i>Not covered:</i></p> <p><i>Speech therapy that is not medically necessary such as:</i></p> <ul style="list-style-type: none"> <li>• <i>Therapy for educational placement or other educational purposes</i></li> <li>• <i>Training to improve fluency or modify dialect</i></li> <li>• <i>Voice therapy for occupation or performing arts</i></li> <li>• <i>Therapy supplies</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

<b>Hearing services (testing, treatment, and supplies)</b>	<b>You pay – Standard Option</b>	<b>You pay – High Option</b>
<ul style="list-style-type: none"> <li>• Hearing testing for adults to determine the need for hearing correction</li> <li>• Hearing testing for children through age 17</li> </ul>	\$15 per office visit	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Hearing aids, testing, and examinations for them</i></li> <li>• <i>All other hearing testing</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Vision services (testing, treatment, and supplies)</b>		
<ul style="list-style-type: none"> <li>• Diagnosis and treatment of diseases of the eye</li> <li>• Eye exam for children to determine the need for vision correction through age 17 (see page 19, Preventive care, children)</li> <li>• Eye refractions (for a written lens prescription for eyeglasses, but not for contact lenses)</li> </ul>	\$15 per office visit	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Eyeglasses</i></li> <li>• <i>Contact lenses</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Radial keratotomy and other refractive surgery such as lasik</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Foot care</b>		
No benefit, except for diabetes	<i>All charges</i>	<i>All charges</i>
<b>Orthopedic and prosthetic devices</b>		
<ul style="list-style-type: none"> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy</li> </ul> <p>Note: We cover surgery necessary to insert the device.</p>	Nothing	Nothing

*Orthopedic and prosthetic devices -- continued on next page*

<b>Orthopedic and prosthetic devices (continued)</b>	<b>You pay – Standard Option</b>	<b>You pay – High Option</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Comfort, convenience, or luxury equipment or features</i></li> <li>• <i>Orthopedic devices and corrective shoes</i></li> <li>• <i>Braces and splints</i></li> <li>• <i>Durable medical equipment</i></li> <li>• <i>External prosthetic devices, except as listed above</i></li> <li>• <i>Prosthetic devices and supplies related to sexual dysfunction</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Take home items</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Durable medical equipment (DME)</b>		
<ul style="list-style-type: none"> <li>• Glucose meter (and control solutions)</li> <li>• External insulin pump</li> <li>• Supplies necessary to operate these items</li> </ul> <p>Note: These items are covered only when obtained through sources designated by the Plan.</p>	50% of our allowance	50% of our allowance
<p><i>Not covered:</i></p> <p><i>All other durable medical equipment</i></p>	<i>All charges</i>	<i>All charges</i>

<b>Home health services</b>	<b>You pay – Standard Option</b>	<b>You pay – High Option</b>
<p>Services ordered by a physician to homebound members residing in the service area:</p> <ul style="list-style-type: none"> <li>• Nursing</li> <li>• Medical social services and home health aide when related to physical therapy, speech therapy, or occupational therapy</li> <li>• Medical supplies included in the plan of care</li> </ul> <p>Note: We cover IV therapy and medications under the prescription drug benefit. We cover physical and occupational therapies under the physical and occupational therapies benefit. We cover speech therapy under the speech therapy benefit.</p>	\$15 per visit	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by you or your family for you or your family's convenience</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i></li> <li>• <i>Care that your physician determines can be appropriately provided in the medical office, hospital, or skilled nursing facility</i></li> <li>• <i>Prosthetics, durable medical equipment, supplies, and drugs (not part of home infusion program)</i></li> <li>• <i>Personal care items</i></li> <li>• <i>Services outside our service areas</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Chiropractic</b>		
<p>Up to a maximum of 20 combined chiropractic and acupuncture visits per calendar year:</p> <ul style="list-style-type: none"> <li>• Chiropractic services for the treatment or diagnosis of neuromusculo-skeletal disorders as set forth in a treatment plan approved by the ASHN</li> <li>• Adjunctive therapy as set forth in a treatment plan approved by the ASHN</li> <li>• X-rays</li> </ul> <p>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, or 800/966-5955 on Kauai, Maui, or Hawaii.</p>	\$15 per office visit	\$10 per office visit

*Chiropractic -- continued on next page*

<b>Chiropractic (continued)</b>	<b>You pay – Standard Option</b>	<b>You pay – High Option</b>
<p>Chiropractic appliances when prescribed by a participating chiropractor and authorized by ASHN.</p> <p>Note: <b>We pay no more than \$50 per calendar year.</b> When the \$50 maximum is reached, you must pay the full retail price for all chiropractic appliances for the remainder of the calendar year.</p>	All charges over \$50	All charges over \$50
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Any services or treatment not authorized by ASHN, except for an initial examination</li> <li>• Services related to the chiropractic treatment that is performed or prescribed by a Plan physician</li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Alternative treatments</b>		
<p>Up to a maximum of 20 combined chiropractic and acupuncture visits per calendar year:</p> <ul style="list-style-type: none"> <li>• Acupuncture services for the treatment or diagnosis of neuromusculo-skeletal disorders, nausea or pain syndromes as set forth in a treatment plan approved by the ASHN</li> <li>• Adjunctive therapy as set forth in a treatment plan approved by the ASHN</li> </ul> <p>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, or 800/966-5955 on Kauai, Maui, or Hawaii.</p>	\$15 per office visit	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Any services or treatment not authorized by ASHN, except for an initial examination</li> <li>• Services related to the acupuncture treatment that is performed or prescribed by a Plan physician</li> <li>• Other alternative treatments such as naturopathic services, hypnotherapy, and biofeedback</li> <li>• Traditional Chinese Herbal Supplements</li> <li>• All other forms of alternative treatment</li> </ul>	<i>All charges</i>	<i>All charges</i>

Educational classes and programs	You pay – Standard Option	You pay – High Option
<p>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.</p>		
<p>Patient education classes, such as:</p> <ul style="list-style-type: none"> <li>• Cholesterol Classes</li> <li>• Living and Learning with Diabetes</li> </ul>	\$15 per visit	\$10 per visit
<p>Lifestyle and health promotion classes, such as:</p> <ul style="list-style-type: none"> <li>• 55 Alive Mature Driving</li> <li>• Body Conditioning</li> <li>• Childbirth Preparation/Lamaze Class</li> <li>• Couples Communication I</li> <li>• Healthier Living-Managing on-going health conditions</li> <li>• Heart Saver (Basic CPR-Course A)</li> <li>• Iyengar Yoga</li> <li>• Managing Chronic Pain</li> <li>• Parenting Patterns Workshop</li> <li>• Prenatal/Post-Partum Exercise</li> </ul>	Class fee varies from \$10 to \$93	Class fee varies from \$10 to \$93
<ul style="list-style-type: none"> <li>• Bariatric Surgery Program</li> </ul>	Class fee is \$850	Class fee is \$850
<p>Other classes (including support groups) such as:</p> <ul style="list-style-type: none"> <li>• Arthritis Support Group</li> <li>• Breastfeeding Your Baby</li> <li>• H.O.P.I.N.G. (Helping Other Parents In Normal Grieving)</li> <li>• Menopausal Years</li> <li>• Mothers Share Group</li> <li>• New Sibling Class/Tour</li> <li>• Stroke Club</li> </ul>	Nothing	Nothing
<p>Smoking Cessation Program</p> <p>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.</p>	\$15 per class	\$10 per class

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

<b>I M P O R T A N T</b>	<p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Plan physicians must provide or arrange your care.</li> <li>• We have no calendar year deductible.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> <li>• 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.).</li> <li>• <b>YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF SOME SURGICAL PROCEDURES.</b> 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.</li> </ul>	<b>I M P O R T A N T</b>
--	--	--

Benefit Description	You pay	
	You pay - Standard Option	You pay - High Option
<b>Surgical procedures</b>		
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care</li> <li>• Pre-surgical testing</li> <li>• Correction of amblyopia and strabismus</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see reconstructive surgery)</li> <li>• 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</li> <li>• Insertion of internal prosthetic devices</li> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> <li>• Insertion of surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs).</li> </ul> <p>Note: We cover surgically implanted time-release contraceptive drugs and intrauterine devices under the prescription drug benefit.</p> <ul style="list-style-type: none"> <li>• Treatment of burns</li> </ul>	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$10 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>

*Surgical procedures -- continued on next page*

<b>Surgical procedures</b> <i>(continued)</i>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
<ul style="list-style-type: none"> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> </ul>	50% of our allowance	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Reconstructive surgery</b>		
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>—the condition produced a major effect on the member’s appearance; and</li> <li>— the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• 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.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>—surgery to produce a symmetrical appearance on the other breast;</li> <li>—treatment of any physical complications, such as lymphedemas; and</li> <li>—breast prostheses and surgical bras and replacements (see prosthetic devices).</li> </ul> </li> </ul> <p>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.</p>	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$10 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Oral and maxillofacial surgery	You pay - Standard Option	You pay - High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones</li> <li>• Surgical correction of cleft lip, cleft palate, or severe functional malocclusion</li> <li>• Removal of stones from salivary ducts</li> <li>• Excision of leukoplakia or malignancies</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures</li> </ul>	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$10 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Shortening of the mandible or maxillae for cosmetic purposes</i></li> <li>• <i>Correction of malloclusion</i></li> <li>• <i>Any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Organ/tissue transplants	You pay - Standard Option	You pay - High Option
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Simultaneous pancreas-kidney</li> <li>• Liver</li> <li>• Lung: Single –Double</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• 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</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> </ul> <p>Note: We cover some directly related medical and hospital expenses of the donor when we cover your transplant. However, there are certain limitations. Please check with our Customer Service Center for further details.</p>	<p>\$15 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$10 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of non-human or artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> <li>• <i>Transportation, lodging, and living expenses</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

<b>Anesthesia</b>	<b>You pay – Standard Option</b>	<b>You pay - High Option</b>
Professional services provided in: <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	Nothing	Nothing

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

<b>I M P O R T A N T</b>	<p><b>Here are some important things to remember about these benefits:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.</li> <li>• We have no calendar year deductible.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> <li>• 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).</li> </ul>	<b>I M P O R T A N T</b>
--	---	--

Benefit Description	You pay	
Inpatient hospital	You pay - Standard Option	You pay - High Option
<p>Room and board, such as:</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations</li> <li>• General nursing care</li> <li>• Meals and special diets</li> </ul> <p>Note: Your coinsurance for room and board will also apply to maternity care and to newborn children.</p> <p>Note: Your physician may prescribe private accommodations or private duty nursing (independent 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.</p>	<p>10% of daily room rate charges</p>	<p>Nothing</p>

*Inpatient hospital -- continued on next page*

<b>Inpatient hospital</b> <i>(continued)</i>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Dressings, casts, and sterile trays</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Administration of blood and blood products</li> </ul> <p>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.</p>	Nothing	Nothing
<ul style="list-style-type: none"> <li>• Diagnostic laboratory tests and X-rays</li> </ul>	Nothing	Nothing
<ul style="list-style-type: none"> <li>• Blood, limited to whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin</li> <li>• Collection, storage, and processing of autologous blood for covered scheduled surgery whether or not the units are used</li> </ul>	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor directed units of blood</i></li> <li>• <i>Custodial care</i></li> <li>• <i>Non-covered facilities</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals, and beds</i></li> <li>• <i>Take home items</i></li> <li>• <i>Private nursing care</i></li> <li>• <i>Any inpatient dental procedures</i></li> <li>• <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

<b>Outpatient hospital or ambulatory surgical center</b>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Dressings, casts, and sterile trays</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> <li>• Administration of blood and blood products</li> <li>• Pre-surgical testing</li> </ul>	\$15 per surgery	\$10 per surgery
<ul style="list-style-type: none"> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> </ul>	50% of our allowance	Nothing
<ul style="list-style-type: none"> <li>• Blood, limited to whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin</li> <li>• Collection, storage and processing of autologous blood for covered scheduled surgery whether or not the units are used</li> </ul>	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor directed units of blood</i></li> <li>• <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Skilled nursing care benefits	You pay - Standard Option	You pay - High Option
<p>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.</p> <p>Services include:</p> <ul style="list-style-type: none"> <li>• Nursing care</li> <li>• Bed and board</li> <li>• Medical social services</li> <li>• Prescribed drugs</li> <li>• Medical supplies</li> </ul> <p>Note: We cover physical and occupational therapies under the physical and occupational therapies benefit. We cover speech therapy under the speech therapy benefit.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals, and beds</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

<b>Hospice care</b>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
<p>If you are diagnosed with a terminal illness with a life expectancy of six months or less, you may elect hospice care.</p> <p>Hospice care is supportive and palliative care (including family counseling) for a terminally ill member when provided by a Plan approved licensed hospice.</p> <p>Short-term inpatient care is limited to respite care, care for pain control, and acute and chronic symptom management.</p> <p>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.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Private duty nursing (independent nursing)</i></li> <li>• <i>Homemaker services</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Ambulance</b>		
Local professional ambulance service when ordered or authorized by a Plan physician	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Transports that we determine are not medically necessary</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

---

## Section 5 (d). Emergency services/accidents

---

<b>I M P O R T A N T</b>	<b>Here are some important things to keep in mind about these benefits:</b>	<b>I M P O R T A N T</b>
	<ul style="list-style-type: none"><li>• 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.</li><li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li><li>• We have no calendar year deductible.</li></ul>	

### 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:

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.

### Emergencies within and outside our service area:

Within our service area, emergency care is provided at Plan hospitals 24 hours a day, seven day a week.

When you are in the service area of another Kaiser Permanente plan, you may obtain emergency care services from Kaiser Permanente medical facilities and providers. 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.

Within or outside our service area, 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.

Post-stabilization care is the service you receive after your treating physician determines that you are clinically stable. We cover post-stabilization care if a Plan Provider provides it or if you obtain authorization from us to receive the care from a non-Plan Provider.

### How to Obtain Authorization

You or a family member must call us at the telephone number on the back of your ID card to:

- Request authorization for post-stabilization care *before* you obtain the care from a non-Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible)
- Notify us that you have been admitted to a non-Plan Hospital. You or a family member must notify us within 48 hours of any admission or as soon as reasonably possible. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you don't notify us within 48 hours of any admission, or as soon as reasonably possible, we will not cover any services and supplies you receive after transfer would have been possible.

Benefit Description	You pay	
	You pay - Standard Option	You pay - High Option
<b>Emergency within our service area</b>		
<ul style="list-style-type: none"> <li>Emergency care at a physician's office</li> <li>Emergency care at an urgent care center</li> <li>Emergency care at a hospital, including physicians' services</li> </ul>	\$25 per visit	\$25 per visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Emergency outside our service area</b>		
At a non-Plan facility: <ul style="list-style-type: none"> <li>Emergency care at a physician's office</li> <li>Emergency care at an urgent care center</li> <li>Emergency care at a hospital, including physicians' services</li> </ul>	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: <ul style="list-style-type: none"> <li>Emergency care in a Kaiser Foundation Hospital in another Kaiser Foundation Health Plan service area</li> </ul> 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
<i>Not covered:</i> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Ambulance</b>		
Professional ambulance service (including air ambulance) when medically appropriate.	20% of our allowance	20% of our allowance
<i>Not covered:</i> <ul style="list-style-type: none"> <li><i>Transports we determine are not medically necessary</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

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

<b>I M P O R T A N T</b>	<p>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.</p> <p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Plan physicians must provide or arrange for your care.</li> <li>• We have no calendar year deductible.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> </ul>	<b>I M P O R T A N T</b>
--	---	--

Benefit Description	You pay	
<b>Mental health and substance abuse benefits</b>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
<p>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.</p> <p>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.</p> <p>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.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions</p>

*Mental health and substance abuse benefits -- continued on next page*

<b>Mental health and substance abuse benefits</b> <i>(continued)</i>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or disorders of children, adolescents, and adults. Outpatient services include:</p> <ul style="list-style-type: none"> <li>• Diagnostic evaluation</li> <li>• Crisis intervention and stabilization for acute episodes</li> <li>• Psychological testing necessary to determine appropriate psychiatric treatment</li> <li>• Psychiatric treatment (including individual and group therapy visits)</li> <li>• Medication evaluation and management</li> </ul> <p>Diagnosis and treatment of alcoholism and drug abuse. Outpatient services include:</p> <ul style="list-style-type: none"> <li>• Detoxification (the withdrawal process from physically-addictive drugs and/or alcohol when withdrawal is likely to cause medical or life-threatening complications)</li> <li>• Treatment and counseling (including individual and group therapy visits)</li> </ul> <p>Note: You may see a Plan outpatient mental health or substance abuse provider without a referral from your primary care physician.</p> <p>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.</p>	<p>\$15 per office visit</p>	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> <li>• Inpatient psychiatric or substance abuse care</li> <li>• Hospital alternative services, such as partial hospitalization, day treatment, and intensive outpatient psychiatric treatment programs</li> <li>• Day treatment programs for substance abuse</li> </ul> <p>Note: All inpatient admissions, hospital alternative services, and day treatment programs require approval by a Plan physician.</p>	<p>10% of daily room charges</p>	<p>Nothing</p>

*Mental health and substance abuse benefits -- continued on next page*

<b>Mental health and substance abuse benefits (continued)</b>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Care that is not clinically appropriate for the treatment of your condition</i></li> <li>• <i>Services we have not approved</i></li> <li>• <i>Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition</i></li> <li>• <i>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</i></li> <li>• <i>Services that are custodial in nature</i></li> <li>• <i>Services rendered or billed by a school or a member of its staff</i></li> <li>• <i>Services provided under a federal, state, or local government program</i></li> <li>• <i>Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

**Limitation**

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

## Section 5 (f). Prescription drug benefits

<b>I M P O R T A N T</b>	<p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• We cover prescribed drugs and medications, as described in the chart beginning on the next page.</li> <li>• 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.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> <li>• We have no calendar year deductible.</li> </ul>	<b>I M P O R T A N T</b>
--	---	--

**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 and only within our service area.  
  
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 refills for maintenance drugs for a 90-day consecutive supply by mail order at a \$20 copayment 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: controlled substances as determined by state and/or federal regulations, bulky items, medications affected by temperature, injectables, and other products or dosage forms identified by the Pharmacy and Therapeutics Committee. We do not send mail order drugs to addresses outside of the State of Hawaii.
- **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 brand name drug), but you request the brand name drug, this drug is not covered and you pay member rates.
- **There are dispensing limitations.** We provide up to a 30-day supply or one cycle of an FDA approved contraceptive drug. Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call their Plan pharmacy.
- **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
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that require a physician's prescription</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Diabetes supplies limited to glucose strips, lancets, and insulin syringes</li> <li>• Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)</li> <li>• Oral immunosuppressive drugs required after a transplant</li> <li>• Oral travel immunizations</li> <li>• Smoking cessation drugs, including nicotine patches. Coverage is limited to one course of treatment per calendar year, if: <ul style="list-style-type: none"> <li>—the drug is prescribed by a Plan physician; and</li> <li>—the member enrolls in and pays the fees for a Plan approved smoking cessation program</li> </ul> </li> <li>• Insulin</li> </ul>	\$10 per prescription	\$10 per prescription
<ul style="list-style-type: none"> <li>• FDA approved contraceptives <ul style="list-style-type: none"> <li>—Oral contraceptives</li> </ul> </li> </ul>	\$10 per cycle	\$10 per cycle
<ul style="list-style-type: none"> <li>—Diaphragms</li> <li>—Cervical caps</li> </ul>	\$10 each	\$10 each
<ul style="list-style-type: none"> <li>—Injectable contraceptive drugs</li> </ul>	\$10 times the expected number of months the medication will be effective	\$10 times the expected number of months the medication will be effective

*Covered medications and supplies -- continued on next page*

Covered medications and supplies <i>(continued)</i>	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> <li>—Intrauterine devices (IUDs)</li> <li>—Implanted time-release contraceptive drugs</li> </ul> <p>Note: We will not refund any portion of the copayment if the IUD is removed or spontaneously expelled, or the implanted time-release contraceptive drug is removed before the end of its lifetime.</p>	\$10 times the expected number of months the medication or device will be effective, not to exceed \$250	\$10 times the expected number of months the medication or device will be effective, not to exceed \$250
<ul style="list-style-type: none"> <li>• Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details.</li> </ul>	50% of our allowance	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs related to non-covered services</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy, except as part of a covered out-of-area emergency</i></li> <li>• <i>Non-prescription drugs</i></li> <li>• <i>Drugs for which there is a non-prescription equivalent available, except those listed on the Plan's formulary and prescribed by a Plan physician</i></li> <li>• <i>Vitamins and nutritional supplements that can be purchased without a prescription</i></li> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs related to enhancing athletic performance (such as weight training and body building)</i></li> <li>• <i>Drugs to shorten the duration of the common cold</i></li> <li>• <i>Any packaging other than the dispensing pharmacy's standard packaging</i></li> <li>• <i>Replacement of lost, stolen, or damaged drugs and accessories</i></li> <li>• <i>Medical supplies (such as dressings and antiseptics), except as listed above</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

## Section 5 (g). Special features

Feature	Description
<p><b>Services from other Kaiser Permanente Plans</b></p>	<p>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 must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting. 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.</p> <p>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.</p> <p>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.</p> <p>At the time you register for services, you will be asked to pay the charges required by the local Plan.</p> <p>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.</p>
<p><b>Interpretive services</b></p>	<p>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 at 800/966-5955 on Kauai, Maui, or Hawaii.</p>
<p><b>24 hour advice line</b></p>	<p>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.</p> <p>During clinic hours, you may call your clinic.</p> <p>During after hours, you may call 808/432-7700 on Oahu or 800/467-3011 on Kauai, Maui, or Hawaii.</p> <p>Hours of operation are:</p> <ul style="list-style-type: none"> <li>• Monday through Friday, 5 p.m. – 8 a.m.</li> <li>• Noon, Saturday, through 8 a.m., Monday</li> <li>• Holidays, all day</li> </ul>

<p><b>Travel benefit</b></p>	<p>Kaiser Permanente’s travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are temporarily 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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 90 days by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring.</li> <li>• You pay \$25 for each follow-up or continuing care office visit. We deduct this amount from the payment we make to you.</li> <li>• We pay no more than \$1200 each calendar year.</li> <li>• For more information about this benefit call the Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui, or Hawaii.</li> </ul> <p>Claims should be submitted to Affiliated Care, Kaiser Foundation Health Plan, Inc., 80 Mahalani Street, Wailuku, Hawaii 96793.</p> <p><i>The following are not included in your travel benefits coverage:</i></p> <ul style="list-style-type: none"> <li>• <i>Non-emergency hospitalization</i></li> <li>• <i>Infertility treatments</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> <li>• <i>Transplants</i></li> <li>• <i>DME</i></li> <li>• <i>Prescription drugs</i></li> <li>• <i>Home health services</i></li> </ul>
<p><b>Flexible benefits option</b></p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative treatment</li> <li>• We review alternative treatment on an outgoing basis</li> <li>• By approving an alternative treatment, we cannot guarantee you will get it in the future</li> <li>• The decision to offer an alternative treatment is solely ours, and we may withdraw it at any time and resume regular contract benefits</li> <li>• Our decision to offer or withdraw alternative treatments is not subject to OPM review under the disputed claims process</li> </ul>

---

**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 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

<b>I M P O R T A N T</b>	<p><b>Here are some important things to keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>Plan dentists must provide or arrange your care.</li> <li>We have no calendar year deductible.</li> <li>We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.</li> </ul>	<b>I M P O R T A N T</b>
--	--	--

<b>Accidental injury benefit</b>	<b>You pay - Standard Option</b>	<b>You pay - High Option</b>
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 may 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. Eligible fee is the maximum amount an HDS Member Dentist agrees to accept for a dental procedure. Participating HDS dentists are referred to as HDS Member Dentists. Non-participating HDS dentists are referred to as Non-Member Dentists.

*Dental benefits begin on the next page*

Service	You pay - Standard Option	You pay - High Option
<p>We cover diagnostic and preventive care services when provided through Hawaii Dental Service:</p> <ul style="list-style-type: none"> <li>• Examinations – once every calendar year</li> <li>• Bitewing X-rays – twice every calendar year</li> </ul>	Nothing	Nothing
<ul style="list-style-type: none"> <li>• Other X-rays – limited to one full mouth series of X-rays (including bitewings) once every three years</li> <li>• Prophylaxis (cleaning) – once every calendar year</li> <li>• Stannous fluoride – once every calendar year and for dependent children only</li> <li>• Palliative treatment – for relief of pain</li> </ul>	20% of eligible fees	20% of eligible fees
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic dental services</i></li> <li>• <i>Prosthetic services or devices (including crowns and bridges) started prior to the date you became eligible under this Program</i></li> <li>• <i>Orthodontic services</i></li> <li>• <i>Dental services not listed as covered</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

---

## 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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service; or
- Services provided or arranged by criminal justice institutions for members confined therein.

---

## 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 Kauai, Oahu, or Hawaii.

When you must file a claim – such as for services you receive outside of the Plan's service area – 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;
- Follow up services rendered out-of-area
- 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 at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui, or Hawaii 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
------	-------------

- |          |   |
|----------|---|
| <b>1</b> | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"><li>(a) Write to us within 6 months from the date of our decision; and</li><li>(b) Send your request to us at: Regional Appeals Coordinator, Affiliated Care, Kaiser Foundation Health Plan, Inc., 501 Alakawa Street, Honolulu, HI 96817; and</li><li>(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ul>  |
| <b>2</b> | <p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"><li>(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>(b) Write to you and maintain our denial -- go to step 4; or</li><li>(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.</li></ul>   |
| <b>3</b> | <p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>   |
| <b>4</b> | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>• 90 days after the date of our letter upholding our initial decision; or</li><li>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li><li>• 120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, D.C. 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"><li>• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li><li>• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li><li>• Copies of all letters you sent to us about the claim;</li><li>• Copies of all letters we sent to you about the claim; and</li><li>• Your daytime phone number and the best time to call.</li></ul> <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> |

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.

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 may call OPM's Health Insurance Group 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 or a covered family member have coverage 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.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

- **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.

- **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.

**Claims process when you have the Original Medicare Plan --** You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 808/432-5955 on Oahu, or 800/966-5955 on Kauai, Maui, or Hawaii.

**(Primary payer chart begins on next page.)**

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare 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.

<b>Primary Payer Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payer for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
1) Are an active employee with the Federal government and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
2) Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case)	✓*	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) 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)	✓*	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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)	✓**	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
<b>C. When either you or your spouse are eligible for Medicare solely due to disability and you</b>		
1) Are an active employee with the Federal government and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
2) Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
<b>D. Are covered under the FEHB Spouse Equity provision as a former spouse</b>	✓	

\* Unless you have FEHB coverage through your spouse who is an active employee

\*\* Workers' Compensation is primary for claims related to your condition under Workers' Compensation

## • Medicare+Choice

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

**This Plan and our Medicare+Choice plan:** You may enroll in our Medicare+Choice 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. There is no additional premium to enroll in Senior Advantage. If you would like information about our Medicare+Choice plan, please call 808/432-5955 on Oahu and 800/966-5955 on Kauai, Maui, or Hawaii. Your Kaiser Permanente Senior Advantage-FEHBP benefits that we lowered or waived are:

### High Option

- Office visits: \$5 copayment for physicians and other health professionals visits
- 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: Pneumococcal 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 copayment
- Durable medical equipment: 20% copayment
- External prosthetics: 20% copayment
- Blood, blood transfusions, and blood products: \$0
- Dialysis: \$0
- Manual manipulation of the spine to correct subluxation: \$5 copayment
- Intraocular lens after cataract surgery: 20% copayment

### **Standard Option**

- Office visits: \$10 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: \$10 copayment
- Routine physical and hearing exams: \$10 copayment for each routine physical and hearing exam
- Immunizations: Pneumococcal pneumonia, flu, and hepatitis B vaccines at no charge
- Urgently needed care: \$10 copayment for each visit to a Plan facility
- One routine eye exam each year: \$10 copayment
- Durable medical equipment: 20% copayment
- External prosthetics: 20% copayment
- Blood, blood transfusions, and blood products: \$0
- Dialysis: \$0
- Manual manipulation of the spine to correct subluxation: \$10 copayment
- Intraocular lens after cataract surgery - 20% copayment

**This Plan and another plan's Medicare+Choice plan:** You may enroll in another plan's Medicare+Choice plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare+Choice 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+Choice plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare+Choice plan so we can correctly coordinate benefits with Medicare.

**Suspended FEHB coverage to enroll in a Medicare+Choice plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare+Choice plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare+Choice 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.

#### **• TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

**Suspended FEHB coverage to enroll in TRICARE or CHAMPVA:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under the program.

• **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.

**Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

• **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

---

<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	(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. Custodial care that lasts 90 days or more is sometimes known as Long term care.
<b>Deductible</b>	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.
<b>Experimental or investigational services</b>	<p>We consider a service, supply or drug to be experimental when the service or supply, including a drug:</p> <ol style="list-style-type: none"><li>(1) has not been approved by the FDA; or</li><li>(2) is the subject of a new drug or new device application on file with the FDA; or</li><li>(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</li><li>(4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or</li><li>(5) is subject to the approval or review of an Institutional Review Board; or</li><li>(6) requires an informed consent that describes the service as experimental or investigational.</li></ol> <p>We do not cover a service, supply, or drug that we consider experimental.</p> <p>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.</p>
<b>Group health coverage</b>	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, it is either the amount we have negotiated with the non-Plan provider, or if we do not have a negotiated amount, the amount that we believe is usual and customary for the service or supply, compared to the billed charges. Our allowance is based upon the reasonableness of the billed charges. If the billed 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

---

### Coverage information

- **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 can get information about enrolling in the FEHB Program** See [www.opm.gov/insure](http://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 your FEHB coverage. These materials tell you:
  - 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.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 benefits until the effective date of your coverage with your new plan. 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.

- **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 (TCC), or a conversion policy (a non-FEHB individual policy).

- **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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's website, [www.opm.gov/insure](http://www.opm.gov/insure).

- **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](http://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](http://www.opm.gov/insure/health)); refer to the "TCC and HIPAA" frequently asked questions. 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.

---

## Two new Federal Programs complement FEHB benefits

---

### Important information

OPM wants to be sure you know about two new Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20 to more than 40 percent on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** covers long term care costs not covered under the FEHB.

### The Federal Flexible Spending Account Program - *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!!*

There are two types of FSAs offered by the FSAFEDS Program:

#### **Health Care Flexible Spending Account (HCFSA)**

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. **Note:** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is \$3,000 annually. The minimum amount is \$250 annually.

#### **Dependent Care Flexible Spending Account (DCFSA)**

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250 annually. **Note:** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at [www.fsafeds.com](http://www.fsafeds.com).

- Call the toll –free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

## **What is SHPS?**

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

## **Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB—you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the “use-it-or-lose-it” rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at [www.fsafeds.com](http://www.fsafeds.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSAs pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 15 and detailed throughout this brochure. Your HCFSAs will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under the High Option of this Plan, typical out-of-pocket expenses include: office visit copayments, prescription drug copayments, and durable medical equipment coinsurance.

Under the Standard Option of this Plan, typical out-of-pocket expenses include: office visit copayments, prescription drug copayments, and durable medical equipment coinsurance.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS website at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will also be lower. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

<b>Annual Tax Savings Example</b>	<b>With FSA</b>	<b>Without FSA</b>
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into a FSA:	\$ 2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$ 2,000
Your real spendable income is:	\$34,193	\$33,617
<b>Your tax savings:</b>	<b>\$576</b>	<b>-\$0-</b>

**Note:** This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), as well as your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

**Health care expenses**

The HCFSA is tax-free from the first dollar. In addition, you may be reimbursed from the HCFSA at any time during year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal income tax return.

## **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit [www.fsafeds.com](http://www.fsafeds.com) and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

Probably not. While there is an administrative fee of \$4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com website or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS website** at [www.fsafeds.com](http://www.fsafeds.com), or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: [fsafeds@shps.net](mailto:fsafeds@shps.net)
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

## The Federal Long Term Care Insurance Program

### It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

**To find out more and  
to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

---

## Index

---

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

- Accidental injury to sound natural teeth 50
- Allergy tests 22
- Allowance, our 64
- Alternative treatment 27
- Ambulance 38, 39, 40
- Anesthesia 33
- Autologous bone marrow transplant 32
- Biopsies 30
- Blood and blood plasma 35, 36
- Breast cancer screening 18
- Casts 35, 36
- Changes for 2004 10
- Chemotherapy 22
- Chiropractic 26
- Cholesterol tests 18
- Coinsurance 15, 63, 64
- Colorectal cancer screening 18
- Congenital anomalies 29
- Contraceptive devices and drugs 21, 44, 45, 46
- Coordination of benefits 57, 58
- Covered providers 11, 12
- Deaf and hearing impaired service 72
- Deductible 15, 63
- Dental care 50, 51
- Diagnostic services 17, 18, 35, 36
- Disputed claims review 55, 56
- Donor expenses (transplants) 32
- Dressings 35, 36
- Drugs, prescription 44, 45, 46
- Durable medical equipment (DME) 25
- Educational classes and programs 28
- Effective date of enrollment 66
- Emergency 39, 40
- Experimental or investigational 52, 63
- Eyeglasses 24
- Family planning 21
- Fecal occult blood test 18
- Flexible benefits option 48
- General Exclusions 52
- Hearing services 24
- Home health services 26
- Hospice care 38
- Hospital 34, 35, 36
- Immunizations 19
- Infertility 21, 22
- Inpatient hospital benefits 34, 35
- Insulin 45
- Laboratory and pathological services 17, 18, 35, 36
- Magnetic Resonance Imagings (MRIs) 18
- Mail Order Prescription Drugs 44
- Mammograms 18
- Maternity Benefits 20
- Medicaid 62
- Medically necessary 64
- Medicare 57, 58, 59, 60, 61
- Mental Conditions/Substance Abuse Benefits 41, 42, 43
- Newborn care 17, 20
- Non-FEHB Benefits 15
- Nurse
  - Nurse Anesthetist 35
  - Nurse Practitioner 11
  - Registered Nurse 47
- Nursery charges 20
- Obstetrical care 20
- Occupational therapy 23
- Oral and maxillofacial surgery 31
- Orthopedic devices 24, 25
- Out-of-pocket expenses 15
- Oxygen 35, 36
- Pap test 18
- Physical examination 19, 20
- Physical therapy 23
- Precertification 49, 56
- Prescription drugs 44, 45, 46
- Preventive care, adult 18, 19
- Preventive care, children 19, 20
- Prior approval 14, 56
- Prostate cancer screening 18
- Prosthetic devices 24, 25
- Psychotherapy 43
- Radiation therapy 22
- Renal dialysis 22
- Room and board 34
- Second surgical opinion 17
- Services from other Kaiser Permanente Plans 47
- Skilled nursing care
  - benefits 17, 26, 37
- Smoking cessation 28, 45
- Speech therapy 23
- Splints 25
- Sterilization procedures 29
- Subrogation 62
- Substance abuse 41, 42, 43
- Surgery 29, 30
  - Anesthesia 33
  - Oral 31
  - Outpatient 36
  - Reconstructive 30
- Syringes 45
- Temporary continuation of coverage 67
- Transplants 32
- Travel benefit 48
- Treatment therapies 22
- TRICARE and CHAMPVA 61
- Vision services 24
- Well child care 19, 20
- Workers' compensation 62
- X-rays 18, 35, 36, 51
- 24 hour nurse line 47

## Summary of benefits for Kaiser Foundation Health Plan, Inc. – Hawaii Region – Standard Option – 2004

- **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	17-33
Services provided by a hospital: • Inpatient..... • Outpatient.....	10% of daily room rate charges \$15 per office visit	34-35 36
Emergency benefits: • In-area ..... • Out-of-area .....	\$25 per visit 20% of our allowance	40 40
Mental health and substance abuse treatment: .....	Regular cost sharing	41-43
Prescription drugs .....	\$10 per prescription	44-46
Dental Care.....	Various copayments based on procedure rendered	50-51
Vision Care.....	\$15 per office visit	24
Special features: Services from other Kaiser Permanente Plans; Interpretive services; 24 hour advice line; Travel benefit; Flexible benefits option; Travel assistance		47-49
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after \$1,500/Self Only or \$4,500/Family enrollment per year Some costs do not count toward this protection	15

## Summary of benefits for Kaiser Foundation Health Plan, Inc. – Hawaii Region – High Option – 2004

- **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	17-33
Services provided by a hospital: • Inpatient..... • Outpatient.....	Nothing \$10 per office visit	34-35 36
Emergency benefits: • In-area ..... • Out-of-area .....	\$25 per visit 20% of our allowance	40 40
Mental health and substance abuse treatment: .....	Regular cost sharing	41-43
Prescription drugs .....	\$10 per prescription	44-46
Dental Care.....	Various copayments based on procedure rendered	50-51
Vision Care.....	\$10 per visit	24
Special features: Services from other Kaiser Permanente Plans; Interpretive services; 24 hour advice line; Travel benefit; Flexible benefits option; Travel assistance		47-49
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after \$1,500/Self Only or \$4,500/Family enrollment per year Some costs do not count toward this protection	15

## 2004 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 a FEHB guide is published 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.

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

High Option Self Only	631	\$120.84	\$40.28	\$261.82	\$87.27	\$142.99	\$18.13
High Option Self and Family	632	\$259.80	\$86.60	\$562.90	\$187.63	\$307.43	\$38.97
Standard Option Self Only	634	\$97.16	\$32.39	\$210.52	\$70.17	\$114.98	\$14.57
Standard Option Self and Family	635	\$208.90	\$69.63	\$452.61	\$150.87	\$247.20	\$31.33