# Kaiser Foundation Health Plan, Inc.

**A NOT-FOR-PROFIT HEALTH PLAN – HAWAII MARKET**

## 2026 Summary of Important Changes for Contract Renewals for the Kaiser Permanente Group Plans

*(These changes are subject to regulatory approval)*

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

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

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

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

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

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

1. **Orthodontic Care for the Treatment of Orofacial Anomalies (from birth).** For orthodontic care for the treatment of orofacial anomalies (from birth), the state of Hawaii Insurance Commissioner will increase the maximum benefit per treatment phase to $7,122 per calendar year (was $6,927).

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

1. **Genetic Testing and Screening**. Clarify that genetic tests and screening are covered when medically necessary.
2. **Hearing aids**. Clarify that consultation for hearing aids are covered.
3. **Inpatient Hospital**. Clarify that antibiotics are covered.

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

**KP HI Platinum 0/15**
- Annual prescription drug copayment maximum will be $5,000 per member/$10,000 for family of 2 or more members (was $2,500/$5,000).

**KP HI Gold 300/20 – B**
- Annual prescription drug copayment maximum will be $6,700 per member/$13,400 for family of 2 or more members (was $6,100/$12,200).

**KP Platinum Added Choice - $20 (in-network)**
- Annual prescription drug copayment maximum will be $3,075 per member/$6,150 for family of 2 or more members (was $2,350/$4,700).

Kaiser Foundation Health Plan, Inc.

# Kaiser Permanente Hawaii's Guide to Your Health Plan

KP HI Platinum 0/20 Plan

JANUARY 2026

# Benefit and Payment Chart

## About this Chart

This benefit and payment chart:

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

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

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

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

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

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

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

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

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

| Description | Cost Share |
|---|---|
| • Testing | 20% of Applicable Charges for the first 10 visits (combined total for laboratory, imaging and testing), and 50% of Applicable Charges for additional visits |
| • Immunizations | None |
| • Contraceptive drugs and devices | None |
| • Self-administered drug prescriptions | 20% of Applicable Charges for the first 10 prescriptions, and 50% of Applicable Charges for additional prescriptions |
| House Calls | |
| • Primary Care | $20 per visit |
| • Specialty Care | $20 per visit |
| Telehealth | Cost Share, if applicable, will vary depending on Service |
| **Laboratory, Imaging, and Testing** | |
| Laboratory | |
| • Basic | $20 per day |
| • Specialty | 20% of Applicable Charges |
| Imaging | |
| • General | $20 per day |
| • Specialty | 20% of Applicable Charges |
| Testing | |
| • Allergy Testing | |
| ○ Primary Care | $20 per visit |
| ○ Specialty Care | $20 per visit |
| • Skilled-Administered Drugs | 20% of Applicable Chares |
| • Diagnostic Testing | 20% of Applicable Charges |
| **Surgery** | |
| Outpatient Surgery and Procedures | |
| • Primary Care | $20 per visit |
| • Specialty Care | $20 per visit |
| • Total Care Settings | Included in Total Care Services |
| Reconstructive Surgery | |
| • Primary Care | $20 per visit |
| • Specialty Care | $20 per visit |
| • Covered Mastectomy | 20% of Applicable Charges |
| • Total Care Settings | Included in Total Care Services |
| **Total Care Services** | |
| *You may only pay a single Cost Share for covered benefits you receive in Total Care Service settings. Here are examples:* | |
| Inpatient Hospital Services | 20% of Applicable Charges |

| Description | Cost Share |
|---|---|
| Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC) | 20% of Applicable Charges |
| Emergency Services | 20% of Applicable Charges |
| Observation | 20% of Applicable Charges |
| Skilled Nursing Facility | 20% of Applicable Charges for up to 120 days per Accumulation Period |
| Dialysis | |
| • Dialysis | 20% of Applicable Charges |
| • Equipment, Training and Medical Supplies for home Dialysis | None |
| Radiation Therapy | 20% of Applicable Charges |
| **Ambulance** | |
| Air Ambulance | 20% of Applicable Charges |
| Ground Ambulance | 20% of Applicable Charges |
| **Physical, Occupational, and Speech Therapy** | |
| Physical and Occupational Therapy | |
| • Medical Office | $20 per visit |
| • Home Health Care | None |
| • Total Care Settings | Included in Total Care Services |
| Speech Therapy | |
| • Medical Office | $20 per visit |
| • Home Health Care | None |
| • Total Care Settings | Included in Total Care Services |
| **Home Health Care and Hospice Care** | |
| Home Health Care | None |
| Hospice Care | None |
| Physician Visits | |
| • Primary Care | $20 per visit |
| • Specialty Care | $20 per visit |
| **Chemotherapy Services** | |
| • Primary Care | $20 per visit |
| • Specialty Care | $20 per visit |
| • Total Care Settings | Included in Total Care Services |
| **Internal, External Prosthetics Devices and Braces** | |
| Implanted Internal Prosthetics, Devices and Aids | |
| • Medical Office | None |
| • Total Care Settings | Included in Total Care Services |
| External Prosthetics Devices | |
| • Outpatient | 10% of Applicable Charges |

| Description | Cost Share |
|---|---|
| • Total Care Settings | Included in Total Care Services |
| Braces | |
| • Outpatient | 10% of Applicable Charges |
| • Total Care Settings | Included in Total Care Services |
| **Durable Medical Equipment** | |
| Durable Medical Equipment | |
| • Outpatient | 10% of Applicable Charges |
| • Total Care Settings | Included in Total Care Services |
| Oxygen (for use with DME) | |
| • Outpatient | 10% of Applicable Charges |
| • Total Care Settings | Included in Total Care Services |
| Repair or Replacement | |
| • Outpatient | 10% of Applicable Charges |
| • Total Care Settings | Included in Total Care Services |
| Diabetes Equipment | 50% of Applicable Charges |
| Home Phototherapy Equipment | None |
| **Behavioral Health – Mental Health and Substance Abuse** | |
| Mental Health Care | |
| • Medical Office | $20 per visit |
| • Total Care Settings | Included in Total Care Services |
| Chemical Dependency Care | |
| • Medical Office | $20 per visit |
| • Total Care Settings | Included in Total Care Services |
| Autism Care | |
| • Primary Care | $20 per visit |
| • Specialty Care | $20 per visit |
| **Transplants** | |
| Transplant Care for Transplant Recipients | |
| • Primary Care | $20 per visit |
| • Specialty Care | $20 per visit |
| • Total Care Settings | Included in Total Care Services |
| Transplant Services for Transplant Donors (based on health plan approval) | |
| • Primary Care | $20 per visit |
| • Specialty Care | $20 per visit |
| • Total Care Settings | Included in Total Care Services |
| Related Prescription Drugs | See prescription drugs in this *Benefit Summary* |
| Transplant Evaluations | |
| • Primary Care | $20 per visit |

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

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

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

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

Note: We also cover some outpatient drugs and supplies in the Prescription Drugs section in *Chapter 3: Benefit Description* of this Guide. For Senior Advantage members, we also cover some outpatient drugs and supplies in the Medical Benefits Chart in the front of the EOC and for Part D members, in Chapters 5 and 6. This Rider amends the Kaiser Permanente Senior Advantage Evidence of Coverage (EOC) to include additional coverage for Prescription Drugs. The information in this Rider only applies to the Prescription Drugs covered under this Rider.

# Benefit Summary

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

| Description | Cost Share |
|---|---|
| Well Rx Program drugs* | Not applicable |

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

# Benefit Description

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

**Covered Drugs and Supplies**

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

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

Notes: Immunizations are described in *Chapter 3: Benefit Description* under *Routine and Preventive.* Contraceptive drugs and devices are described in *Chapter 3: Benefit Description* under *Routine and Preventive.* Diabetic equipment and supplies are described in *Chapter 3: Benefit Description* under *Durable Medical Equipment (DME)* and *Prescription Drug*. Senior Advantage members, see the Medical Benefits Chart.

**Cost Share for Covered Drugs and Supplies**

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

The Cost Share amounts count toward the Annual Copayment Maximum (or the Annual Prescription Drug Copayment Maximum if you have one listed in the above Benefit Summary). This applies for each covered prescription. Note: For Senior Advantage members, these amounts do not count towards the out-of-pocket maximum. Medicare has rules about what counts and what does not count toward your out-of-pocket costs.

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

**Day Supply Limit**
The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-consecutive-day (or any other number of days) supply for you. Dispensing limitations may apply within the 30-consecutive-day supply period for certain drugs. When you pay the Cost Share shown in the Benefit Summary, you will receive the prescribed supply up to the day supply limit.

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

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

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

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

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

- ***Brand-name Drug***. The first U.S. Food and Drug Administration (FDA) approved version of a drug. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent. Brand-name drugs include single source drugs (where there is only one approved product available for that active ingredient, dosage form, route of administration, and strength).
- ***Generic Drug.*** A drug that contains the same active ingredient as a Brand-Name Drug, is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent, and having the same active ingredients(s) as the Brand-name Drug. Generic Drugs are produced and sold under their Generic names after the patent of the Brand-Name drug expires. Generally, Generic Drugs cost less than Brand-Name Drugs, and must be identical in strength, safety, purity, and effectiveness.
- ***Generic Maintenance Drug.*** A specific Generic Drug to treat chronic conditions and is on Health Plan's approved list. Note: Not all Generic Drugs to treat chronic conditions are considered Generic Maintenance Drugs.
- ***Maintenance Drug.*** A drug to treat chronic conditions, such as asthma, high blood pressure, diabetes, high cholesterol, cardiovascular disease, and mental health.
- ***Specialty Drug.*** A very high-cost drug approved by the U.S. Food and Drug Administration (FDA).
- ***Annual Prescription Drug Copayment Maximum.*** (If not specified in this Benefit Summary, does not apply.) The Annual Prescription Drug Copayment Maximum is the maximum amount for Pharmacy

Dispensed Drugs you pay out of your pocket in a calendar year. Once you meet the Annual Prescription Drug Copayment Maximum, you are no longer responsible for Cost Share amounts for covered Pharmacy Dispensed Drugs for the remainder of that calendar year. For Senior Advantage members with Part D, please see Chapter 6 in your Evidence of Coverage.

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

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

**About Our Drug Formulary**

Our drug formulary is considered a closed formulary, which means that medications on the list are usually covered under the prescription drug Rider. However, drugs on our formulary may not be automatically covered under your prescription drug Rider depending on which plan you've selected. Even though nonformulary drugs are generally not covered under your prescription drug Rider, your Kaiser Permanente physician can sometimes request a nonformulary drug for you, specifically when formulary alternatives have failed or use of nonformulary drug is Medically Necessary, provided the drug is not excluded under the prescription drug Rider.

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

Note: If your prescription allows refills, there are limits to how early you can receive a refill. The Kaiser Permanente mobile app and online kp.org will let you know when it's time for a prescription refill.

# Services Not Covered

- Drugs for which a prescription is not required by law (e.g. over-the-counter drugs) including condoms, contraceptive foams and creams or other non-prescription substances used individually or in conjunction with any other prescribed drug or device. This exclusion does not apply to tobacco cessation drugs and products as described in *Chapter 3: Benefit Description* under *Prescription Drugs*.
- Drugs in the same therapeutic category as the non-prescription drug, as approved by the Kaiser Permanente Pharmacy & Therapeutics Committee.
- Drugs obtained from a non-Kaiser Permanente pharmacy or non-contracted pharmacy.
- Non-prescription vitamins.
- Drugs used for weight management.
- Drugs when used primarily for cosmetic purposes.
- Medical supplies such as dressings and antiseptics.
- Reusable devices such as blood glucose monitors and lancet cartridges.
- Diabetes supplies such as blood glucose test strips, lancets, syringes and needles, except Senior Advantage Members with Medicare Part D covers syringes and needles under this Prescription Drug Rider. Note: Diabetes supplies are covered in *Chapter 3: Benefit Description* under *Diabetic Supplies*.
- Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate.
- Brand-name/specialty drugs requested by a Member when there is a generic equivalent.
- Prescribed drugs that are necessary for or associated with excluded or non-covered services.
- Drugs not included on the Health Plan formulary, unless a non-formulary drug has been specifically prescribed and authorized by the licensed Prescriber.
- Drugs to shorten the duration of the common cold.
- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.

- Drugs and supplies to treat sexual dysfunction.
- Drugs used to enhance athletic performance (including weight training and body building).
- Replacement of lost, stolen or damaged drugs or supplies.

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

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

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

# Benefit Summary

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

# Benefit Description

### Maternity Care
Covered, for delivery.

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

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

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

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

### Observation
Covered when prescribed by a Physician.

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

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

For Senior Advantage members, this Rider amends the Kaiser Permanente Senior Advantage *Evidence of Coverage (EOC)* to include additional coverage for Infertility Treatment.

# Benefit Summary

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

# Benefit Description

## Special Services for Women

### Artificial Insemination

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

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

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

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

# Benefit Summary

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

# Benefit Description

## Primary Care Office Visits for Children

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

Notes:

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

# Kaiser Foundation Health Plan, Inc. – Hawaii

# Kaiser Permanente Fit Rewards

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

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

| | | |
|---|---|---|
| **Kaiser Permanente Fit Rewards – Calendar Year** | **<u>This Fit Rewards Program includes a basic fitness facility and exercise center membership</u>**<br>• Eligible Members may enroll with a contracted network fitness facility<br>• Program enrollment includes standard fitness club services and features including access to:<br>  ○ cardiovascular equipment<br>  ○ resistance/strength equipment<br>  ○ classes which are routinely included in the general membership fee as part of the monthly fee, and for which the contracted fitness club does not typically require a fee per session, per week, per month, or some other time period<br>  ○ amenities such as saunas, steam rooms, and whirlpools, where available<br>• Eligible Members should verify services and features with the contracted fitness facility<br>**<u>Note:</u>**<br>• Eligible members have a $200 annual program fee✦<br>• Eligible members must meet the 45-day, 30-minute per session activity requirement by end of calendar year 2026 to receive a reimbursement for fitness activities<br>Or | **No Charge** |
| | **<u>Home Fitness Program</u>**<br>• Eligible Members may select one of the available home fitness kits per calendar year | **No Charge** |
| | **<u>Fitness website</u>**<br>• All eligible Members have access to Optum One Pass Select web-based services such as facility provider search, enrollment functions, educational content, exercise videos, fitness tools and trackers. | |

The following are excluded from the Program:

- Instructor-led classes for which the contracted fitness club charges a separate fee (and which are not routinely included in the general membership fee as part of the monthly membership fee).
- Personal trainers, classes, facility services, amenities, and products or supplies for which the contracted fitness facility charges Members an additional fee.
- Access to fitness or exercise facilities that are not part of the contracted network.
- Home fitness kits not provided through the program.
- Enrollment for Members not specifically listed as eligible for this program, as defined by the Group and Kaiser Permanente.
- Enrollment for Members under the age of 16.

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✦ Members must pay their fee directly to Optum One Pass Select prior to using services. Kaiser Permanente Fit Rewards is a value-added service and not part of your medical benefits. Fees do not count toward the eligible Member's health benefit plan's Annual Copayment Maximum.

Kaiser Permanente shall not undertake to provide or to assure the availability and access to gym facilities approved by Optum One Pass Select.

Kaiser Permanente Fit Rewards is part of the fitness program, administered by Optum One Pass Select. Optum One Pass Select logo is a federally registered trademark of Optum One Pass Select and used with permission herein. The details of this program are subject to change. For the most current details and specifics, please visit kp.org/fitrewards.

# Kaiser Foundation Health Plan, Inc. – Hawaii

# ACA Small Group Amendment

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

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

# Benefit Summary

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

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

# Benefit Description

## Physical, Occupational and Speech Therapy

### Habilitative Services

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

Habilitative services and devices include:

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

## Prescription Drugs

### Self-Administered Drugs in accordance with USPSTF

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

## Special Services for Women

### Family Planning Visits

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

## Behavioral Health – Mental Health and Substance Abuse

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

## Emergency Services from Dentists

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

## Miscellaneous Medical Treatments

### Erectile Dysfunction

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

### Temporomandibular Joint Dysfunction (TMJ)

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

### Vision Appliances and Procedures

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

### Pediatric Vision Care

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

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

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

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

# Services Not Covered

## Miscellaneous Exclusions

**Habilitative Services**: You are not covered for:

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

# Kaiser Foundation Health Plan, Inc. – Hawaii

# Optical $200 Rider

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

For Senior Advantage members, this Rider amends the Kaiser Permanente Senior Advantage *Evidence of Coverage (EOC)* to include additional coverage for Eyewear. The information in this Rider only applies to the Eyewear covered under this Rider.

# Benefit Summary

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

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

# Benefit Description

## Optical Eyewear and Services and Pediatric Vision Care generally

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

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

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

We also cover routine eye examinations for eyeglasses in the Routine and Preventive section in *Chapter 3: Benefit Description* of this Guide. We also cover diagnosis, treatment and continued care for conditions related to disease or injuries of the eye by an eye specialist in the Office Visits section in *Chapter 3: Benefit Description* of this Guide. We also cover care in the hospital in the Total Care Services section in *Chapter 3: Benefit Description* of this Guide. For Senior Advantage members, eye exams and other eyewear are described in the Medical Benefits Chart.

## Optical Eyewear and Services

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

**Glasses frame/lens, lens treatments, prescription safety glasses, corrective sunglasses**
Covered, when two lenses (at least one of which must have refractive value) are put into the frame. For members up to age 19, the lens material will be impact resistant polycarbonate.

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

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

## Pediatric Vision Care

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

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

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

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

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

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

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

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

### Pediatric Vision Care options

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

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

# Services Not Covered

- Any medical services or eyewear from non-Kaiser Permanente providers or non-Kaiser Permanente optical facilities
- Optional eyeglass lens treatments such as anti-reflective coating, color coating and tinted lenses, polycarbonate lenses (for members over 19 years), photochromic lenses, ultraviolet protected lenses
- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Non-prescription eyewear such as colored contact lenses, non-prescription athletic eyewear, non-prescription industrial safety, and non-prescription sunglasses

- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Contact lens exams (if the allowance has been exhausted)
- All costs exceeding the stated allowance in the *Benefit Summary*.

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

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

For Senior Advantage members, this Rider amends the Kaiser Permanente Senior Advantage *Evidence of Coverage* (EOC) to include additional coverage for Dental Care.

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

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

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

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

DELTA DENTAL

HDS
Hawaii Dental Service

# Summary of Dental Benefits
## Kaiser Small Group Plan - Group No. 2995
## Effective: 01/01/2026

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

| | ADULTS - AGE 19 & OLDER | CHILDREN – AGE 18 & UNDER |
|---|---|---|
| **PLAN MAXIMUM** The most HDS will pay for each person for all covered dental services performed during the calendar year. | $1,200<br>per yr | N/A |
| **MAXIMUM OUT OF POCKET (MOOP) The most you will pay before your dental plan begins to pay 100% of your benefit. Out-of-pocket payments made for non-covered services, alternate benefits and non-medically necessary orthodontics will not count toward the MOOP.** | N/A | $450<br>per child per yr<br>$900<br>for 2+ children per yr |
| | **HDS PLAN PAYS** | |
| **DIAGNOSTIC** | | |
| Examinations | 100%<br>2x/yr | 100%<br>2x/yr |
| Bitewing X-rays | 100%<br>1x/yr | 100%<br>2x/yr |
| Other X-rays | 70%<br>Full mouth X-rays 1x/5 yrs | 70%<br>Full mouth X-rays 1x/5 yrs |
| **PREVENTIVE** | | |
| Cleanings | 100%<br>2x/yr | 100%<br>2x/yr |
| Fluoride | Not Covered | 100%<br>2x/yr<br>Through age 18 |
| Silver Diamine Fluoride | 100% | 100% |
| Space Maintainers | Not Covered | 100%<br>Through age 18 |

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

| | | |
|---|---|---|
| Fixed Bridges & Dentures | 50%<br>1x/7yrs per tooth | 50%<br>1x/7yrs per tooth |
| Implants | 50% | Not Covered |
| OTHER SERVICES | | |
| Adjunctive General Services | 70% | 70%<br>Nitrous Oxide, IV sedation and hospital care is covered. |
| Emergency Treatment of Dental Pain (Palliative Treatment)<br>Once per visit per dental office for relief of pain but not to cure | 70% | 70% |
| Athletic Mouth Guards | Not Covered | 70%<br>1x/24-months |
| ORTHODONTICS | | |
| | 50%<br>For dependent children through age 25. $1000 lifetime maximum amount paid (1/2 at banding) | 50%<br>For dependent children through age 25. $1000 lifetime maximum amount paid (1/2 at banding) |
| Medically Necessary Ortho<br>Limited to dependent children for those cases involving repair of the cleft lip and/or cleft palate, severe facial birth defects, or an incurred injury that affects the function of speech, swallowing, and/or chewing. | Not Covered | 50%<br>Through age 18 |

Special Considerations: For members who have started orthodontic services under a group plan, HDS will continue orthodontic coverage for members moving to this group and will continue appropriate payments to participating dentists. If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred. Self-administered or at-home applications (or any type of "do it yourself") orthodontics is not a covered benefit. Orthodontics must be performed by a licensed dentist or supervised staff. Assessment of salivary flow is covered.

# Access to HDS Information 24/7

*Visit HDS Online at HawaiiDentalService.com to:*

### ACCESS YOUR ACCOUNT

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

### SEARCH

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

### DOWNLOAD & PRINT

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

### CHECK

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

### VIEW

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

### REQUEST

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

# How to Contact HDS

### Customer Service Representatives

**From Oahu: (808) 529-9248**

**Toll-free: 1-844-379-4325**

***Customer Service Call Center Hours:***

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

*Excluding HDS observed holidays,*

*visit HawaiiDentalSevice.com/about/holidays*

*for our HDS' observed holiday schedule.*

**Walk-in Office Hours:**

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

### Send Written Correspondence to:

*Hawaii Dental Service*

*Attn: Customer Service*

*900 Fort Street Mall, Suite 1900*

*Honolulu, HI 96813-3705*

*E-mail: CS@HawaiiDentalService.com*

**FAX:**

*From Oahu: (808) 529-9366*

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

# Kaiser Foundation Health Plan, Inc. – Hawaii

# Alternative Medicine Rider E - 20 visits/$20

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

For Senior Advantage members, this Rider amends the Kaiser Permanente Senior Advantage Evidence of Coverage (EOC) to include additional coverage for Alternative Medicine. The information in this Rider only applies to the Alternative Medicine covered under this Rider.

# Benefit Summary

| Description | Cost Share |
|---|---|
| **Chiropractic, acupuncture, massage therapy and naturopathy services** | |
| **Up to a maximum of 20 office visits per calendar year.**<br>**This Rider does not cover services which are performed or prescribed by a Kaiser Permanente physician or other Kaiser Permanente health care provider.** Services must be performed and received from Participating Chiropractors, Participating Acupuncturists, Participating Massage Therapists, and Participating Naturopaths of **American Specialty Health (ASH)**. Covered Services include:<br>• **Chiropractic services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders which are authorized by ASH and performed by a Participating Chiropractor.<br>• **Acupuncture services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea or Pain Syndromes which are authorized by ASH and performed by a Participating Acupuncturist.<br>• **Massage therapy services** for the treatment and diagnosis of myofascial/musculoskeletal disorder, a musculoskeletal functional disorder, pain syndromes or lymphedema which are referred by a Participating Chiropractor or Kaiser Permanente Physician, authorized by ASH and performed by a Participating Massage Therapist.<br>• **Naturopathy services** limited to noninvasive modalities such as diathermy, electrical stimulation, hot and cold packs, hydrotherapy, manipulation, range of motion exercises, and therapeutic ultrasound which are authorized by ASH and performed by a Participating Naturopath.<br>• **Adjunctive therapy** as set forth in a treatment plan approved by ASH, which may involve chiropractic modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation; acupuncture therapies such as acupressure, moxibustion, and cupping; and other therapies.<br>• **Diagnostic tests** are limited to those required for further evaluation of the Member's condition and listed on the payor summary and fee schedule. Medically necessary x-rays, radiologic consultations, and clinical laboratory studies must be performed by either an appropriately certified Participating Chiropractor, Participating Naturopath who is acting within the scope of their license or certification under applicable law, or staff member or referred to a facility that has been credentialed to meet the criteria of ASH. Diagnostic tests must be performed or ordered by a Participating | $20 copayment per office visit |

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

# Benefit Description

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

**Definitions**

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

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

Covered conditions and services are limited to those the Participating Naturopath is qualified to treat or perform pursuant to state licensure and scope of practice.

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

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

**Services and Benefits**

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

# Services Not Covered

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

- Any Services of chiropractors or chiropractic Services, except as described in this Rider.
- Any Services and supplies related to acupuncture, except as described in this Rider.
- Any massage therapy Services, except as described in this Rider.
- Any Services of naturopaths or naturopathy Services, except as described in this Rider.
- Any Chiropractic service or treatment not furnished by a Participating Chiropractor and not provided in the Participating Chiropractor's office.
- Any Acupuncture service or treatment not furnished by a Participating Acupuncturist and not provided in the Participating Acupuncturist's office.
- Any Massage Therapy service or treatment not furnished by a Participating Massage Therapist.
- Any Naturopathy service or treatment not furnished by a Participating Naturopath and not provided in the Participating Naturopath's office.
- Any massage services rendered by a provider of massage therapy services that are not delivered in accordance with the massage benefit plan and payor summary, including but not limited to limited massage services rendered directly in conjunction with chiropractic or acupuncture services.
- Examination and/or treatment of conditions other than Neuromusculo-skeletal Disorders from Participating Chiropractors; Neuromusculo-skeletal Disorders, Nausea, or Pain Syndromes from Participating Acupuncturists; or myofascial/musculoskeletal disorders, musculoskeletal functional disorders, Pain Syndromes, or lymphedema from Participating Massage Therapists.
- Services, lab tests, x-rays and other treatments not documented as medically necessary or as appropriate.
- Services, lab tests, x-rays and other treatments classified as experimental or investigational.
- Diagnostic scanning and advanced radiographic imaging, including Magnetic Resonance Imaging (MRI), CAT scans, and/or other types of diagnostic scanning or therapeutic radiology; thermography; bone scans, nuclear radiology, any diagnostic radiology other than plain film studies.
- Alternative medical services not accepted by standard allopathic medical practices including, but not limited to, hypnotherapy, behavior training, sleep therapy, weight programs, lomi lomi, educational programs, podiatry, rest cure, aroma therapy, osteopathy, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing.
- Vitamins, minerals, nutritional supplements, botanicals, ayurvedic supplements, homeopathic remedies or other similar-type products.
- Nutritional supplements which are Native American, South American, European, or of any other origin.
- Traditional Chinese herbal supplements.
- Nutritional supplements obtained by Members through a health food store, grocery store or by any other means.
- Prescriptive and non-prescriptive drugs, injectables and medications.
- Transportation costs, such as ambulance charges.
- Hospitalization, manipulation under anesthesia, anesthesia or other related services.
- Diagnostic tests, laboratory services and tests for Acupuncture and Massage Therapy.
- Services or treatment for pre-employment physicals or vocational rehabilitation.
- Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance.

- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances (except as covered in this Rider) or durable medical equipment.
- Services provided by a chiropractor, acupuncturist, massage therapist, or naturopath outside the State of Hawaii.
- All auxiliary aids and services, such as interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
- Adjunctive therapy not associated with acupuncture or chiropractic services.
- Services and/or treatment which are not documented as Medically Necessary services.
- Any services or treatment not authorized by ASH, except for an initial examination.
- Any office visits beyond the maximum limit (stated in the *Benefit Summary*) per calendar year.

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

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