

# Kaiser Foundation Health Plan, Inc. Hawaii Region

[my.kp.org/federalemmployees](http://my.kp.org/federalemmployees)



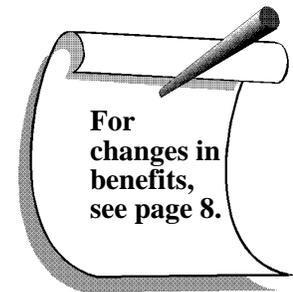
**KAISER  
PERMANENTE®**

## 2007

### A Health Maintenance Organization (High and Standard Options)

**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 or work in our geographic service area to enroll. See page 6 for requirements.**



*This Plan has excellent accreditation from the NCQA.  
See the 2007 Guide for more information on accreditation.*

**Enrollment code 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>

## **Important Notice from Kaiser Foundation Health Plan, Inc. Hawaii Region About Our Prescription Drug Coverage and Medicare**

OPM has determined that Kaiser Foundation Health Plan, Inc., Hawaii Region's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare, but you still need to follow the rules in this brochure for us to cover your prescriptions. We will only cover your prescription if it is written by a Plan provider and obtained at a Plan pharmacy or through our Plan mail service delivery program, except in an emergency or urgent care situation.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

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### **Please be advised**

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If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

#### **Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Introduction

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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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. Rates are shown on the back cover of this brochure.

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## Plain Language

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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 the structure of this brochure, let OPM 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 U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits 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 that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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 (EOB) statements 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 and explain the situation.

If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street NW Room 6400**

**Washington, DC20415-1100**

- 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.

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## **Preventing medical mistakes**

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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.**

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.

- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

### **3. Get the results of any test or procedure.**

- Ask when and how you will get the results of tests 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 reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- [www.ahrq.gov/path/beactive.htm](http://www.ahrq.gov/path/beactive.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 health care 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 health care for you and your family.
- [www.talkaboutrx.org](http://www.talkaboutrx.org). 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 health care 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 health care delivery system.

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## Section 1 Facts about this HMO plan

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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. We give you a choice of enrollment in a High Option or a Standard Option.

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.**

### **General features of our High and Standard Options**

#### **How we pay providers**

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Hawaii Permanente Medical Group physicians practice as a group and pool their skills and experience for your benefit. Your Plan physicians may be paid in a number of ways, including salary, capitation, per diem rates, case rates, or fee for service. If you would like further information about the way Plan physicians are paid to provide or arrange medical and hospital care for Health Plan members, please call the Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui or Hawaii, or 877/447-5990 TTY.

#### **Your rights**

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, our providers, and our 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 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
- 49 years in existence
- Our three entities – Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and Hawaii Permanente Medical Group, Inc. (HPMG, a for-profit Hawaii corporation) – 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 877/447-5990 TTY, or write to the Health Plan office at 711 Kapiolani Blvd., Honolulu, Hawaii 96813. You may also contact us by fax at 808/432-5300 or visit our Web site at [my.kp.org/federalemployees](http://my.kp.org/federalemployees).

#### **Service Area**

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

The Islands of Oahu, Kauai and Maui

The Island of Hawaii (except zip codes 96718, 96772, and 96777).

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente or allied plan service area, you can receive visiting member care from designated providers in that area . 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 in Section 5(g); and for emergency care obtained from any non-Plan provider, as described in Section 5(d). 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.

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## Section 2 How we change for 2007

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Do not rely on these change descriptions; this Section 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.

### Changes to this Plan

#### Changes to High Option only

- Your share of the non-Postal premium will increase by 0.5% for Self Only or increase 0.5% for Self and Family under the High Option.
- We now cover professional services of physicians at your home. You pay \$12 per visit (see page 17).
- We changed your payment for pre-surgical testing from \$12 per surgery to 10% of our allowance (see page 35).
- We changed your payment for diagnostic tests for treatment of psychiatric conditions from \$12 per office visit to 10% of our allowance (see page 42).

#### Changes to Standard Option only

- Your share of the non-Postal premium will decrease by (1.0%) for Self Only or decrease (1.0%) for Self and Family under the Standard Option.
- We now cover professional services of physicians at your home. You pay \$20 per visit (see page 17).
- We changed your payment for pre-surgical testing from \$20 per surgery to 50% of our allowance (see page 35).
- We changed your payment for diagnostic tests for treatment of psychiatric conditions from \$20 per office visit to 50% of our allowance (see page 41).

#### Changes to both High and Standard Options

- We now cover infertility services when either family member has been voluntarily sterilized (see page 17).
- We revised the speech therapy benefit. Two-month limit no longer applies; however, therapy must be short-term and covered according with Plan clinical guidelines (see page 17).
- We no longer cover travel immunizations (see pages 17 and 46).
- We revised the amount you pay and services we cover when you temporarily visit another Kaiser Permanente Plan (see page 47).

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## Section 3 How you get care

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### 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 letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 10 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 Center, 711 Kapiolani Boulevard, Honolulu, Hawaii 96813. You may also request replacement cards through our Web site at [my.kp.org/federalempleyees](http://my.kp.org/federalempleyees).

### 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 Web site at [my.kp.org/federalempleyees](http://my.kp.org/federalempleyees).

- **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 18 Plan facilities conveniently located on the Islands of Oahu, Maui and Hawaii; and through specialists, hospitals and other providers in the community following an authorized referral. On Kauai, we contract with independent physicians and other clinicians to provide primary, specialty, and emergency care for our members.

We list Plan facilities in our provider directory, which we update periodically. The list is also on our Web site at [my.kp.org/federalempleyees](http://my.kp.org/federalempleyees).

You must receive your health care services at affiliated Plan facilities, except if you have an emergency. If you are visiting another Kaiser Permanente or allied plan service area, you may receive health care services at those Kaiser Permanente facilities. See Section 5 (g), Special features, for more details. Under the circumstances specified in this brochure, you may 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, online 24/7 at [my.kp.org/federalempleyees](http://my.kp.org/federalempleyees), 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 hospitalized when your enrollment begins**

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 and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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

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

These provisions apply only to the benefits of the hospitalized person. 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 cases, 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, available from a Plan physician, 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: bariatric surgery, prostheses, durable medical equipment, 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 submitting it in writing by mailing or delivering it to Kaiser Foundation Health Plan, Inc., Attn: Regional Appeals Office, 501 Alakawa St., Honolulu, HI 96817, or by fax to 808/432-7518. 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.

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## Section 4 Your cost for covered services

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You must share the costs 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 certain services.

Example: When you see your primary care physician, you pay a copayment of \$12 (High Option) or \$20 (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 \$20 charge for each bill sent for unpaid services.

**Fees when you miss a medical appointment** If you miss a medical appointment, we will charge you \$15, unless you cancel your appointment at least 24 hours in advance.

Note: Affiliated physician offices and other providers and facilities may bill you an additional charge along with any unpaid copayments, coinsurance or for missed appointments that you fail to cancel.

**Your catastrophic protection out-of-pocket maximum** 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
- Breast prostheses following a mastectomy
- Internal prosthetic devices
- 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.

**Carryover**

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

**High and Standard Option Benefits**

See page 8 for how our benefits changed this year. Page 73 and page 74 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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## Section 5 High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui or Hawaii or at our Web site at [my.kp.org/federalemployees](http://my.kp.org/federalemployees).

Kaiser Foundation Health Plan of Hawaii has been a leader in offering high quality integrated health care to FEHB for more than 45 years. Our seamless delivery system provides convenient, comprehensive care all under one roof. You can come to almost any one of our medical facilities and see your primary care physician, pediatrician, Ob/Gyn or specialist, fill prescriptions, have mammograms, complete lab work, plus X-rays and more. Also, our sophisticated health technology gives you the ability 24 hours a day and 7 days a week to book appointments, send secure messages to your provider, refill prescriptions, or research medical conditions.

In 2004, Kaiser Permanente's HMO, Medicare, and Medicaid Plans received "Excellent Accreditation" – the highest level of accreditation possible – from the National Committee for Quality Assurance (NCQA), an independent, non-profit organization that measures the quality of America's health care. In addition, our Moanalua Medical Center on Oahu is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Today, the Health Plan offers two benefit plans to Federal members, the High and Standard Options. Both Options are designed to include preventive and acute care services provided by our Plan providers, but offer different levels of benefits and services for you to choose between to best fit your health care needs.

Our **High Option** provides the most comprehensive benefits. Our FEHB High Option includes:

- \$12 copay for an office visit with your primary care physician (PCP)
- \$12 copay for an office visit with a specialist
- No charge for hospital room and board
- 10% coinsurance for outpatient labs and X-rays
- \$10 copay per prescription or refill for covered drugs obtained at a Plan medical office pharmacy

We also offer a **Standard Option**. With the Standard Option your copayments and coinsurance may be higher than for the High Option, but the bi-weekly premium is lower. Specific benefits of our FEHB Standard Option include:

- \$20 copay for an office visit with your primary care physician (PCP)
- \$20 copay for an office visit with a specialist
- 10% coinsurance for hospital room and board
- 50% coinsurance for outpatient labs and X-rays
- \$10 copay per prescription or refill for covered drugs obtained at a Plan medical office pharmacy

Please review this brochure carefully to learn which of our Kaiser Foundation Health Plan of Hawaii FEHB options is best for you. If you would like more information about our benefits please contact us at 808/432-5955 on Oahu or 800/966-5955 on Kauai, Maui, or Hawaii or visit our Web site at [my.kp.org/federalemployees](http://my.kp.org/federalemployees).

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
	High Option	Standard Option
<b>Diagnostic and treatment services</b>		
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> <li>• In a physician’s office</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> <li>• In an urgent care center</li> <li>• Initial examination of a newborn child covered under a family enrollment</li> </ul>	\$12 per office visit	\$20 per office visit
Professional services of physicians and other health care professionals <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
<ul style="list-style-type: none"> <li>• At home</li> </ul>	\$12 per visit	\$20 per visit
<b>Lab, X-ray and other diagnostic tests</b>		
Tests, such as: <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>	10% of our allowance	50% of our allowance

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Preventive care, adult</b></p> <p>Preventive screenings:</p> <ul style="list-style-type: none"> <li>• Lipid Evaluation</li> <li>• Chlamydia detection</li> <li>• Fecal occult blood test</li> <li>• Osteoporosis screening</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• Preventive screenings are determined by the Plan's clinical guidelines.</li> <li>• You should consult with your Plan physician to determine what is appropriate for you.</li> </ul>	Nothing after the \$12 office visit	Nothing after the \$20 office visit
<p>Routine screenings, such as:</p> <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>	Nothing after the \$12 office visit	Nothing after the \$20 office visit
<ul style="list-style-type: none"> <li>- Double contrast barium enema – every five years starting at age 50</li> </ul>	10% of our allowance	50% of our allowance
<ul style="list-style-type: none"> <li>- Colonoscopy screening – every ten years starting at age 50</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• You should consult with your physician to determine what is appropriate for you.</li> <li>• We cover fecal occult blood test under preventive screenings.</li> </ul>	Nothing after the \$12 office visit	Nothing after the \$20 office visit
<ul style="list-style-type: none"> <li>• Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</li> </ul> <p>Note: You should consult with your physician to determine what is appropriate for you.</p>	10% of our allowance	50% of our allowance
<ul style="list-style-type: none"> <li>• Routine Pap test</li> </ul>	Nothing after the \$12 office visit	Nothing after the \$20 office visit
<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> <p>Note: You should consult with your physician to determine what is appropriate for you.</p>	Nothing after the \$12 office visit	Nothing after the \$20 office visit
<p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):</p>	Nothing	Nothing

*Preventive care, adult - continued on next page*

Benefit Description	You pay	
<b>Preventive care, adult (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<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 vaccines, annually</li> <li>• Pneumococcal vaccines, age 65 and over</li> </ul>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Travel immunizations</i></li> <li>• <i>Physical exams and related reports and paperwork required for:</i> <ul style="list-style-type: none"> <li>- <i>Obtaining or continuing employment</i></li> <li>- <i>Insurance</i></li> <li>- <i>Sports, camps</i></li> <li>- <i>Attending schools</i></li> <li>- <i>Travel.</i></li> </ul> </li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Preventive care, children</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Preventive screenings:</p> <ul style="list-style-type: none"> <li>• Anemia and lead screening</li> <li>• Newborn metabolic screening</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• Preventive screenings are determined by the Plan’s clinical guidelines.</li> <li>• You should consult with your Plan physician to determine what is appropriate for you.</li> </ul>	Nothing after the \$12 office visit	Nothing after the \$20 office visit
<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>- Hearing 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>	\$12 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Travel immunizations</i></li> <li>• <i>Physical exams and related reports and paperwork required for:</i> <ul style="list-style-type: none"> <li>- <i>Obtaining or continuing employment</i></li> <li>- <i>Insurance</i></li> <li>- <i>Sports, camps</i></li> </ul> </li> </ul>	<i>All charges.</i>	<i>All charges.</i>

*Preventive care, children - continued on next page*

Benefit Description	You pay	
<b>Preventive care, children (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>- <i>Attending schools</i></li> <li>- <i>Travel.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Maternity care</b>	<b>High Option</b>	<b>Standard Option</b>
<p>After confirmation of pregnancy, routine maternity (obstetrical) care as determined by a Plan physician, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postpartum 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> <li>• We cover non-routine maternity care the same as for illness and injury. See Section 5(a) for medical services and supplies provided by physicians and other health care professionals, Section 5(b) for surgical and anesthesia services provided by physicians and other health care professionals, Section 5(c) for services provided by a hospital or other facility and ambulance services, and Section 5(d) for emergency services.</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>

Benefit Description	You pay	
	High Option	Standard Option
<b>Family planning</b>		
A broad range of voluntary family planning services, limited to: <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>	\$12 per office visit	\$20 per office visit
<i>Not covered:</i> <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>		
Diagnosis and treatment of involuntary infertility such as: <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>	\$12 per office visit	\$20 per office visit
One in vitro fertilization (IVF) procedure per lifetime (for females who qualify under Hawaii law) <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
<i>Not covered:</i> <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> </ul>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
	High Option	Standard Option
<b>Allergy care</b>		
<ul style="list-style-type: none"> <li>Allergy testing</li> <li>Allergy treatment and injections</li> </ul>	\$12 per office visit	\$20 per office visit
Allergy serum	Nothing	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> <li>Provocative food testing</li> <li>Sublingual allergy desensitization.</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Treatment therapies</b>	<b>High Option</b>	<b>Standard Option</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 on page 32.</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>	\$12 per office visit	\$20 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered.</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Physical and occupational therapies</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Short-term therapy per condition if significant, measurable improvement in physical function 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 when you have a total or partial loss of bodily function due to illness or injury</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>Your Plan physician must order your therapy under an individual treatment plan.</li> <li>Therapy is provided by the appropriate physical or occupational therapist as designated by your Plan physician.</li> </ul>	<p>\$12 per outpatient visit</p> <p>Nothing for inpatient</p>	<p>\$20 per outpatient visit</p> <p>Nothing for inpatient</p>

*Physical and occupational therapies - continued on next page*

Benefit Description	You pay	
<b>Physical and occupational therapies (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>The therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury as determined by your Plan physician in accord with Plan clinical guidelines.</li> </ul>		
<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> <li><i>Therapy for deficits due to developmental delay.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Speech therapy</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Short-term therapy is covered for a condition if significant, measurable improvement in appropriate rehabilitative function can be expected within that period:</p> <ul style="list-style-type: none"> <li>Speech therapy by speech therapists when medically necessary</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>Your Plan physician must order your therapy under an individual treatment plan.</li> <li>Therapy is provided by the appropriate speech therapist as designated by your Plan physician.</li> <li>The therapy must be necessary to restore/improve neurological and/or musculoskeletal function as determined by your Plan physician in accord with Plan clinical guidelines.</li> </ul>	<p>\$12 per outpatient visit</p> <p>Nothing for inpatient</p>	<p>\$20 per outpatient visit</p> <p>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>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
	High Option	Standard Option
<b>Hearing services (testing, treatment, and supplies)</b>		
Hearing testing to determine the need for hearing correction	\$12 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other hearing testing</i></li> <li>• <i>Hearing aids, including testing, and examinations for them.</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>	\$12 per office visit	\$20 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>		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	\$12 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></li> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).</i></li> </ul>	<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 (when chosen instead of a surgically implanted breast implant)</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• We cover surgery necessary to insert the device.</li> </ul>	50% of our allowance	50% of our allowance

*Orthopedic and prosthetic devices - continued on next page*

Benefit Description	You pay	
	High Option	Standard Option
<b>Orthopedic and prosthetic devices (cont.)</b>		
<ul style="list-style-type: none"> <li>• These items are covered only when preauthorized in writing by the Plan and when obtained through sources designated by the Plan.</li> </ul>		
<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>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>	<b>High Option</b>	<b>Standard Option</b>
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <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 preauthorized in writing by the Plan and obtained through sources designated by the Plan.</p>	50% of our allowance	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other durable medical equipment</i></li> <li>• <i>Repair and adjustment due to misuse or loss.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Home health services</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Services and medical supplies 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>Notes:</p>	No charge except \$12 for each physician visit	No charge except \$20 for each physician visit

*Home health services - continued on next page*

Benefit Description	You pay	
	High Option	Standard Option
<b>Home health services (cont.)</b>		
<ul style="list-style-type: none"> <li>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.</li> <li>The services are covered only if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.</li> </ul>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Nursing care requested by, or for the convenience of, the patient or the patient's family</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 of our service areas.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Chiropractic</b>	<b>High Option</b>	<b>Standard Option</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: Members may self-refer for the initial examination to Participating Chiropractors of American Specialty Health Networks™ (ASHN). Subsequent services or treatment must be authorized by ASHN, and performed by and received from Participating Chiropractors of ASHN. Contact Kaiser Permanente Customer Service Center at 808/432-5955 on Oahu, or 800/966-5955 on Kauai, Maui or Hawaii.</p>	\$12 per office visit	\$20 per office visit
<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
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>

*Chiropractic - continued on next page*

Benefit Description	You pay	
<b>Chiropractic (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <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>	<b>High Option</b>	<b>Standard Option</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: Members may self-refer for the initial examination to Participating Acupuncturists of American Specialty Health Networks™ (ASHN). Subsequent services or treatment must be authorized by ASHN, and performed by and received from Participating Acupuncturists of ASHN. Contact Kaiser Permanente Customer Service Center at 808/432-5955 on Oahu, or 800/966-5955 on Kauai, Maui or Hawaii.</p>	\$12 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <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>
<b>Educational classes and programs</b>	<b>High Option</b>	<b>Standard Option</b>
<p>General health education services include patient education classes which are educational programs directed toward members who have specific diagnosed medical conditions whereby members are taught self-care skills to understand, monitor, manage and/or improve their condition.</p> <p>General health education services, such as:</p> <ul style="list-style-type: none"> <li>Kidney Education Class</li> <li>Living Well with Diabetes</li> </ul>	\$12 per visit	\$20 per visit
<ul style="list-style-type: none"> <li>Bariatric Surgery Program</li> </ul>	Class fee is \$1,000	Class fee is \$1,000

*Educational classes and programs - continued on next page*

Benefit Description	You pay	
Educational classes and programs (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> <li>• Smoking Cessation Program</li> </ul> <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>	\$12 per class	\$20 per class
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Educational classes and programs not offered through this Plan.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>

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

**Important things you should keep in mind about these benefits:**

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

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Surgical procedures</b></p> <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>• Correction of amblyopia and strabismus</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (<i>see Reconstructive surgery</i>)</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> <li>• Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual has either a body mass index (BMI) of 40 or greater, or a BMI of 35 up to 39.9 when a combination of certain severe or life threatening medical conditions directly related to obesity are also present such as sleep apnea, diabetes, degenerative joint disease of weight-bearing joints; eligible members must be at least 18 years of age or older</li> </ul>	<p>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>

*Surgical procedures - continued on next page*

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Surgical procedures (cont.)</b></p> <ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices. See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• Final approval for surgery requires approval of a multidisciplinary committee, after completion of the Bariatric Surgery Program class (see Section 5 (a)).</li> <li>• You should consult with your physician to determine what is appropriate for you.</li> <li>• See services requiring our prior approval in Section 3</li> </ul>	<p>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<ul style="list-style-type: none"> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> </ul>	<p>\$12 for the procedure</p> <p>See section 5(c) for facility charges</p>	<p>\$20 for the procedure</p> <p>See section 5(c) for facility charges</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>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot.</i></li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
<p><b>Reconstructive surgery</b></p> <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; and 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 of breasts;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>).</li> </ul> </li> </ul>	<p>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>

*Reconstructive surgery - continued on next page*

Benefit Description	You pay	
<b>Reconstructive surgery (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<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>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 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, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation.</i></li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
<b>Oral and maxillofacial surgery</b>	<b>High Option</b>	<b>Standard Option</b>
<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>• Medical and surgical treatment of TMJ (non-dental)</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 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 malocclusion</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>
<b>Organ/tissue transplants</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Solid organ tissue transplants are limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Intestinal transplants <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> </ul> </li> </ul>	<p>\$12 per office visit</p> <p>Nothing for inpatient professional services</p>	<p>\$20 per office visit</p> <p>Nothing for inpatient professional services</p>

*Organ/tissue transplants - continued on next page*  
High and Standard Option Section 5(b)

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> <li>- Small intestine with multiple organs, such as the liver, stomach, and pancreas</li> <li>• Kidney</li> <li>• Simultaneous pancreas-kidney</li> <li>• Liver</li> <li>• Lung: Single –Double</li> <li>• Pancreas</li> </ul>	<p>\$12 per office visit</p> <p>Nothing for inpatient professional services</p>	<p>\$20 per office visit</p> <p>Nothing for inpatient professional services</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the diagnosis and staging description.)</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for               <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Chronic myelogenous leukemia</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> </ul> </li> <li>• Autologous transplants for               <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Advanced neuroblastoma</li> </ul> </li> <li>• Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</li> </ul>	<p>\$12 per office visit</p> <p>Nothing for inpatient professional services</p>	<p>\$20 per office visit</p> <p>Nothing for inpatient professional services</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> <li>• Allogenic transplants for               <ul style="list-style-type: none"> <li>- Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</li> </ul> </li> <li>• Autologous transplants for               <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> </ul> </li> </ul> <p>Limited Benefits – Autologous blood or bone marrow stem cell transplants for breast cancer, myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p>	<p>\$12 per office visit</p> <p>Nothing for inpatient professional services</p>	<p>\$20 per office visit</p> <p>Nothing for inpatient professional services</p>

Benefit Description	You pay	
<b>Organ/tissue transplants (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Note:</p> <ul style="list-style-type: none"> <li>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.</li> </ul>	<p>\$12 per office visit</p> <p>Nothing for inpatient professional services</p>	<p>\$20 per office visit</p> <p>Nothing for inpatient professional 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>High Option</b>	<b>Standard Option</b>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>Hospital (inpatient)</li> <li>Hospital outpatient department</li> <li>Skilled nursing facility</li> <li>Ambulatory surgical center</li> <li>Office</li> </ul>	<p>Nothing</p>	<p>Nothing</p>

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

**Important things you should keep in mind about these benefits:**

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

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Inpatient hospital</b></p> <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>Notes:</p> <ul style="list-style-type: none"> <li>• Your Standard Option coinsurance for room and board will also apply to maternity care and to newborn children.</li> <li>• If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</li> </ul>	Nothing	10% of daily room rate charges
<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, splints, casts, and sterile trays</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</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 need for anesthesia, by itself, is not such a condition.</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> </ul>	20% of our allowance	20% of our allowance

*Inpatient hospital - continued on next page*

Benefit Description	You pay	
	High Option	Standard Option
<b>Inpatient hospital (cont.)</b>		
<ul style="list-style-type: none"> <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>Custodial care and care in an intermediate care facility</i></li> <li><i>Non-covered facilities, such as nursing homes</i></li> <li><i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds</i></li> <li><i>Private nursing care, except when medically necessary</i></li> <li><i>Inpatient dental procedures</i></li> <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> <li><i>Take home items.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Outpatient hospital or ambulatory surgical center</b>	<b>High Option</b>	<b>Standard 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> </ul>	\$12 per surgery	\$20 per surgery
<ul style="list-style-type: none"> <li>Lab, X-ray and other diagnostic tests</li> <li>Pre-surgical testing</li> </ul>	10% of our allowance	50% of our allowance
<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>

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Skilled nursing care benefits</b></p> <p>Up to 100 days per benefit period when you need full-time skilled nursing care. A benefit period begins when you enter a hospital or skilled nursing facility and ends when you have not been a patient in either a hospital or skilled nursing facility for 60 consecutive days.</p> <p>All necessary services are covered including:</p> <ul style="list-style-type: none"> <li>• Room and board</li> <li>• General nursing care</li> <li>• Medical social services</li> <li>• Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility</li> </ul>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care and care in an intermediate care facility</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, and guest meals and beds.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<p><b>Hospice care</b></p> <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>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 provided by a Plan approved licensed hospice. 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>

Benefit Description	You pay	
<b>Ambulance</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Local licensed ambulance service when medically necessary</li> </ul> <p>See Section 5(d) for emergency services.</p>	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>

## Section 5(d) Emergency services/accidents

### Important things you should keep in mind about these benefits:

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

### 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 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui or Hawaii, or 877/447-5990 TTY.

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.

### Urgent care outside our service area:

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appropriate appointment or advice nurse number at a Plan facility. If you are temporarily outside the service area and have an urgent care need due to a sudden and unforeseen illness or injury, we cover the medically necessary services and supplies you receive from a non-Plan provider if we find that the services and supplies were necessary to prevent serious deterioration of your health and they could not be delayed until you are medically able to safely return to the service area or travel to a Plan facility in another Kaiser Permanente plan.

### 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	
Emergency within our service area	High Option	Standard Option
<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> <p>Note: The copayment applies to emergency bed, emergency supplies and emergency physician services. You may also have to pay for additional services, such as lab and X-ray, as specified in Sections 5(a), 5(b), and 5(c).</p>	\$25 per visit	\$25 per visit
<p><i>Not covered:</i></p> <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>
Emergency outside our service area	High Option	Standard Option
<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> <li>• Urgent care at an emergency room</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• The coinsurance applies to emergency bed, emergency supplies and emergency physician services. You may also have to pay for additional services, such as lab and X-ray, as specified in Sections 5(a), 5(b), and 5(c).</li> <li>• We cover continuing or follow-up care under the travel benefit.</li> </ul>	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <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>

*Emergency outside our service area - continued on next page*

Benefit Description	You pay	
<b>Emergency outside our service area (cont.)</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <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>	<b>High Option</b>	<b>Standard Option</b>
Professional ambulance service (including air ambulance) when medically appropriate.	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <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**

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.

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure, and we cover them only when we determine they are medically necessary to treat your condition.
- Plan physicians must provide or arrange for your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Mental health and substance abuse benefits</b></p> <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>Notes:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>	<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>
<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>• Psychiatric treatment (including individual and group therapy visits)</li> <li>• Medication evaluation and management</li> </ul>	<p>\$12 per office visit</p>	<p>\$20 per office visit</p>

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

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> <li>Diagnostic tests</li> </ul>	10% of our allowance	50% of our allowance
<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>Notes:</p> <ul style="list-style-type: none"> <li>You may see a Plan outpatient mental health or substance abuse provider without a referral from your primary care physician.</li> <li>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.</li> </ul>	\$12 per office visit	\$20 per office visit
<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>	Nothing	10% of daily room rate charges
<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> </ul>	<i>All charges.</i>	<i>All charges.</i>

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

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> <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

### Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We have no calendar year deductible.

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

- **Who can write your prescription.** A Plan authorized prescriber 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.

You may obtain mail order prescription forms at any Plan pharmacy, or call the Kaiser Permanente Automated Refill Center at 808/432-5510 on Oahu or at 866/250-1805 on Kauai, Maui or Hawaii, 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 our service area.

- **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.

- **These are the dispensing limitations.** We provide up to a 30-day supply. 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.

Benefit Description	You pay	
Covered medications and supplies	High Option	Standard 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> </ul> <p>Note: We cover glucose meters under the durable medical equipment benefit.</p> <ul style="list-style-type: none"> <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>• 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>	<p>\$10 per prescription</p>	<p>\$10 per prescription</p>
<ul style="list-style-type: none"> <li>• FDA approved contraceptives               <ul style="list-style-type: none"> <li>- Oral contraceptives</li> <li>- Diaphragms</li> <li>- Cervical caps</li> <li>- Injectable contraceptive drugs</li> <li>- Intrauterine devices (IUDs)</li> <li>- Implanted time-release contraceptive drugs</li> </ul> </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>	<p>50% of our allowance</p>	<p>50% of our allowance</p>

*Covered medications and supplies - continued on next page*

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<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 and their associated dose, dosage strengths or dosage forms in the same therapeutic category as a non-prescription drug, that have the same indication as the non-prescription drug, as determined by the Plan Pharmacy and Therapeutics committee</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>Travel immunizations</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 a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered services, copayments and coinsurance described in this FEHB brochure. The 90 day limit on visiting member care does not apply to a Dependent child who attends an accredited college or accredited vocational school.</p> <p>Please call our Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui or Hawaii, to receive more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may obtain visiting member care may change at any time.</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, 24 hours a day, 7 days a week, you may talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when medically appropriate.</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>

*Feature - continued on next page*

Feature	Description
<b>Feature (cont.)</b>	
	<p>Claims should be submitted to Claims Administration, Kaiser Foundation Health Plan, Inc., 80 Mahalani Street, Wailuku, Hawaii 96793.</p> <p><i>The following are a few examples of services 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>Durable medical equipment</i></li> <li>• <i>Prescription drugs</i></li> <li>• <i>Home health services.</i></li> </ul>
<b>Flexible benefits option</b>	<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>
<b>Travel assistance</b>	<p>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:</p> <ul style="list-style-type: none"> <li>• Pre-trip information</li> <li>• Precertification assistance for inpatient hospital stays</li> <li>• Case management assistance</li> <li>• Translation services</li> <li>• Provider location assistance</li> <li>• Medical transport assistance</li> <li>• Emergency medication assistance</li> <li>• Lost document assistance</li> <li>• Emergency messaging</li> <li>• Lost baggage assistance.</li> </ul> <p>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.</p> <p>Members who need assistance should contact World Access. If members are traveling:</p>

*Feature - continued on next page*

Feature	Description
<b>Feature (cont.)</b>	
	<ul style="list-style-type: none"><li>• within the United States, Puerto Rico and the Virgin Islands, call toll free at 866/221-7870;</li><li>• worldwide (outside US, Puerto Rico or Virgin Islands), call collect at 804/673-1497.</li></ul> <p>Both numbers are available 24 hours a day; 365 days a year.</p>

**Section 5(h) Dental benefits**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we pay them only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
	High Option	Standard Option
<b>Accidental injury benefit</b>		
We cover services to promptly repair (but not replace) a sound natural tooth if: <ul style="list-style-type: none"> <li>• damage is due to an accidental injury from trauma to the mouth from violent contact with an external object,</li> <li>• the tooth has not been restored previously, except in a proper manner, and</li> <li>• the tooth has not been weakened by decay, periodontal disease, or other existing dental pathology.</li> </ul>	\$12 per office visit	\$20 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Services for conditions caused by an accidental injury occurring before your eligibility date.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>

**Dental benefit**

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	You Pay	
Service	High Option	Standard 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>Prosthodontic 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>

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## Non-FEHB benefits available to Plan members

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The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

### **Specialized Health Promotion Classes and Support Groups**

In order to aid members in their quest for better health, the Plan makes available a variety of specialized health promotion classes and support groups which include educational program directed to members who wish to make changes in their behavior that reduce health risks and enhance the quality of their lives or maintain their level of health. When available, health promotion classes and support groups may include exercise and fitness, pregnancy and childbirth, self-care and self-improvement, self-care and support, and weight management classes. For more information, you may request a *Health + Wellness Programs and Classes* catalog from our Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Kauai, Maui or Hawaii.

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## Section 6 General exclusions – things we don't cover

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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:

- When a service is not covered, all services, drugs or supplies related to the noncovered service are excluded from coverage;
- Care by non-Plan providers except for authorized referrals, emergencies, travel benefit, or services from other Kaiser Permanente plans (see Emergency services/accidents and Special features);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies 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 (see specifics regarding transplants);
- 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.

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## Section 7 Filing a claim for covered services

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When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain 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 and hospital benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-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 877/875-3805 on Kauai, Oahu or Hawaii.

When you must file a claim – such as for services you received outside of the Plan's service area – submit it on the CMS-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:**

Claims Administration

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 benefits for 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/prior approval required by Section 3:

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: Kaiser Foundation Health Plan, Inc., Regional Appeals Office, 501 Alakawa Street, Honolulu, HI 96817, or by fax at 808/432-7518 or by email to <a href="mailto:kphawaii.appeals@kp.org">kphawaii.appeals@kp.org</a>; 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. 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, DC 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> <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.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p><b>5</b></p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

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## Section 9 Coordinating benefits with other coverage

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### When you have other health coverage

You must tell us if you or a covered family member have coverage under any other 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 or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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.
- Part C (Medicare Advantage): You may enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan, Kaiser Permanente Senior Advantage. Please review the information on Medicare Advantage plans on page 58.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **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 more 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 are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **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.

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 your copayments.

**Claims process when you have the Original Medicare Plan** – You will probably not need 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, or see our website at [my.kp.org/federalempleyees](http://my.kp.org/federalempleyees).

**We do not waive any costs if the Original Medicare Plan is your primary payer.**

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, 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 Advantage plan, the following options are available to you:

**This Plan and our Medicare Senior Advantage plan:** We offer a Medicare Advantage plan known as Kaiser Permanente Senior Advantage at no additional cost to our members eligible for Medicare benefits including Part D, as well as lower copayments and coinsurance at no cost to you. If you have already enrolled and would like to understand your additional benefits in more detail, please refer to your Medicare Annual Notice of Change (ANOC). If you are considering enrolling in our Senior Advantage plan, please call our Customer Service Center at 808/432-5955 on Oahu and 800/966-5955 on Kauai, Maui or Hawaii.

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

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

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in a Medicare Part D PDP and we are the secondary payer, our Kaiser owned and operated pharmacies will not consider the PDP benefits. These Kaiser pharmacies will only provide your FEHB Kaiser benefits.

You will still need to follow the rules in this brochure for us to cover your care. We will only cover your prescription if it is written by a Plan provider and obtained at a Plan pharmacy or through our Plan mail service delivery program, except in an emergency or urgent care situation.

If you enroll in our Kaiser Permanente Senior Advantage plan, you will get all of the benefits of Medicare Part D plus additional benefits because Medicare Part D is included in our plan.

**(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.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
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) and you are not covered under FEHB through your spouse under #1 above	✓	
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) and you are not covered under FEHB through your spouse under #1 above	✓	
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. When you or a covered family member?		
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	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you?		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

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

**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 TRICARE or CHAMPVA.

**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.

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## Section 10 Definitions of terms we use in this brochure

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<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. See page 12.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	<p>(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine.</p> <p>(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.</p> <p>Custodial care that lasts 90 days or more is sometimes known as Long term care.</p>
<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. See page 12.
<b>Experimental or investigational service</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."

<b>Medically necessary</b>	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.
<b>Our allowance</b>	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.
<b>Us/We</b>	Us and we refer to Kaiser Foundation Health Plan, Inc., Hawaii Region.
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11 FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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) for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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 benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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 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 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 2007 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 2006 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

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 provide health coverage to you. However, you may be eligible for your own FEHB coverage under either 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 Federal 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 at [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 information about Federal and State agencies you can contact for more information.

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## Section 12 Three Federal Programs complement FEHB benefits

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### Important information

OPM wants to make sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

Second, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis.

### The Federal Long Term Care Insurance Program – *FLTCIP*

#### It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care 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 options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of 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 future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. 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 about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

### 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.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

**What expenses can I pay with an FSAFEDS account?**

For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums)

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit [www.FSAFEDS.com](http://www.FSAFEDS.com)

**Who is eligible to enroll?**

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit [www.FSAFEDS.com](http://www.FSAFEDS.com) or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

**When can I enroll?**

If you wish to participate, you must make an election to enroll each year by visiting [www.FSAFEDS.com](http://www.FSAFEDS.com) or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

**Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.**

**Who is SHPS?**

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

**Who is BENEFEDS?**

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

**The Federal Employees Dental and Vision Insurance Program – *FEDVIP***

**Important Information**

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

**Dental Insurance**

Dental plans will provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

**Vision Insurance**

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

**What plans are available?**

You can find a comparison of the plans available and their premiums on the OPM website at [www.opm.gov/insure/dentalvision](http://www.opm.gov/insure/dentalvision). This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

**Premiums**

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit [www.opm.gov/insure/dentalvision](http://www.opm.gov/insure/dentalvision).

**Who is eligible to enroll?**

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

**Enrollment types available**

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

**Which family members are eligible to enroll?**

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

**When can I enroll?**

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

**How do I enroll?**

You enroll on the Internet at [www.BENEFEDS.com](http://www.BENEFEDS.com). BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

**When will coverage be effective?**

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

**How does this coverage work with my FEHB plan's dental or vision coverage?**

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on [www.BENEFEDS.com](http://www.BENEFEDS.com), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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## Summary of benefits for the High Option of Kaiser Foundation Health Plan, Inc. - Hawaii Region - 2007

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- **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.

High Option Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		
• Physician visits	\$12 per office visit	17
• Lab, X-ray and other diagnostic tests	10% of our allowance	17
<b>Services provided by a hospital:</b>		
• Inpatient	Nothing	34
• Outpatient	\$12 per visit	35
<b>Emergency benefits:</b>		
• In-area	\$25 per visit	39
• Out-of-area	20% of our allowance	39
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing	41
<b>Prescription drugs:</b>	\$10 per prescription	45
<b>Dental care:</b>	Various copayments based on procedure rendered	50
<b>Vision care:</b>	\$12 per office visit	17
<b>Special features:</b> Services from other Kaiser Permanente Plans; Interpretive services; 24 hour advice line; Travel benefit; Flexible benefits option; Travel assistance		47
<b>Protection against catastrophic costs</b> (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	12

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## Summary of benefits for the Standard Option of Kaiser Foundation Health Plan, Inc. - Hawaii Region - 2007

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- **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.

Standard Option Benefits	You Pay	Page
<b>Medical services provided by physicians:</b>		
• Physician visits	\$20 per office visit	17
• Lab, X-ray and other diagnostic tests	50% of our allowance	17
<b>Services provided by a hospital:</b>		
• Inpatient	10% of daily room rate charges	34
• Outpatient	\$20 per visit	35
<b>Emergency benefits:</b>		
• In-area	\$25 per visit	39
• Out-of-area	20% of our allowance	39
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing	41
<b>Prescription drugs:</b>	\$10 per prescription	45
<b>Dental care:</b>	Various copayments based on procedure rendered	50
<b>Vision care:</b>	\$20 per office visit	24
<b>Special features:</b> Services from other Kaiser Permanente Plans; Interpretive services; 24 hour advice line; Travel benefit; Flexible benefits option; Travel assistance		47
<b>Protection against catastrophic costs</b> (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	12

## 2007 Rate Information for Kaiser Foundation Health Plan, Inc. - Hawaii Region

**Non-Postal rates** apply to most non-Postal employees. 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 a special 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	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
<b>High Option Self Only</b>	631	\$131.38	\$43.79	\$284.66	\$94.88	\$155.46	\$19.71
<b>High Option Self and Family</b>	632	\$282.44	\$94.15	\$611.96	\$203.99	\$334.22	\$42.37
<b>Standard Option Self Only</b>	634	\$90.86	\$30.29	\$196.87	\$65.62	\$107.52	\$13.63
<b>Standard Option Self and Family</b>	635	\$195.36	\$65.12	\$423.28	\$141.09	\$231.18	\$29.30