Member Handbook

IMPORTANT INFORMATION ABOUT YOUR PLAN

KAISER PERMANENTE®

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INTRODUCTION

Thank you for choosing to be a Kaiser Permanente member. We look forward to helping you live a longer, healthier life. This member handbook will help you to learn more about Kaiser Permanente. We hope that you are an active participant in your health care and use our many programs and tools that empower you to thrive.

This member handbook provides general information, not medical advice or benefit coverage. For complete details on your benefit coverage, including exclusions, limitations, and plan terms, please call Member Services at **1-800-966-5955**.

If you are a member of one of the below plans, please refer to the guide that applies to your plan. If you have questions about which guide applies to you, or for instructions on obtaining the correct guide, please contact Member Services.

- Federal Employees Health Benefits Program members
- Kaiser Permanente Added Choice Plan members
- Kaiser Permanente for Individuals and Families Plan members
- Kaiser Permanente Medicare Cost members
- Kaiser Permanente QUEST Integration and QUEST-Net members
- Kaiser Permanente Senior Advantage members

Information in this member handbook is current as of December 2017 and may be subject to change without notice.

PUTTING OUR PATIENTS FIRST

At Kaiser Permanente, everything we do centers on our patients. Because of this, all of our primary care facilities in Hawaii have once again achieved the highest level of Patient-Centered Medical Home recognition from the National Committee for Quality Assurance. We were the first health care organization in Hawaii with multiple sites to achieve this distinction. What this means is that your personal doctor and team will work closely with you to:

- Provide the care you need by monitoring your health.
- Manage your medications.
- Notify you when you need health screenings or lab tests.
- Coordinate care with specialists and other health care providers as needed.

In addition, if you have a chronic condition such as diabetes or high blood pressure, you will learn how to manage it with the guidance and support of your health care team. With this approach, you can take an active role in your health care. We provide multiple methods for you to access medical care conveniently when you need us anytime, anywhere. You can visit us online at **kp.org**, through a computer or mobile device, where you can schedule, view, or cancel routine appointments; email your doctor's office; refill a prescription; review your medical record; and much more. In addition, you can get medical advice 24/7 at **808-432-2000** (Oahu), **808-243-6000** (Maui, Molokai, or Lanai), **808-334-4400** (Hawaii Island), **808-246-5600** (Kauai) or TTY **711**. The medical professional who

assists you will be able to access your electronic record and send updates to your doctor. As a result, you have convenient, coordinated, high-quality, personalized, around-the-clock care from your health care team. We are committed to providing you with the right care, at the right time, in the right place.

PREVENTIVE CARE GUIDELINES

Make a positive impact on your health by following some basic health guidelines and by getting recommended medical screening tests. Healthy lifestyle habits can go a long way toward keeping you well and may potentially add years to your life. These habits include not smoking; eating a low-fat, high-fiber diet; wearing seat belts; and maintaining a regular exercise program.

As your health care partner, we'll do our part by focusing on early detection and timely treatment of disease. To monitor your health and identify symptoms at an early stage, we ask that you follow these preventive care guidelines.

The preventive care guidelines on pages 3 to 6 are for healthy adults and children with no symptoms of illness. Your doctor may recommend that you have some of these tests more often based on the information you provide, including your age, medical history, and lifestyle. Children need frequent health examinations to have their growth and development monitored and to receive immunizations. Preventive care schedules often incorporate these aspects into each visit. The schedules allow for some variation.

PREVENTIVE CARE GUIDELINES FOR CHILDREN AND ADOLESCENTS

Age	Vaccination or screening test*	Checkup
INFLUENZA SEASONALLY FROM AGE 6 MONTHS THROUGH LIFE		
Birth	Hep B (hepatitis B)	
2 weeks		Well-child visit
2 months	DTaP (diphtheria/tetanus/acellular pertussis), Hib (*Haemophilus influenzae* type B), 2nd Hep B, polio vaccine, PCV (pneumococcal conjugate vaccine), 1st rotavirus oral vaccine	Well-child visit
4 months	2nd DTaP, 2nd Hib, 2nd polio vaccine, 2nd PCV, 2nd rotavirus oral vaccine	Well-child visit
6 months	3rd DTaP, 3rd Hib (if needed), 3rd Hep B, 3rd polio vaccine, 3rd PCV, **influenza seasonally**, 3rd rotavirus oral vaccine (if needed)	Well-child visit
9 months	Complete blood count, TB (tuberculosis) skin test if high risk; lead screening	Well-child visit
12 months	1st MMR (measles/mumps/rubella), 1st Hep A (hepatitis A), 1st varicella (chickenpox)	Well-child visit
15 months	4th DTaP, Hib, and PCV at age 15 to 18 months	Well-child visit
18 months	2nd Hep A; 4th DTaP, Hib, and PCV if not completed at 15 months	Well-child visit
2 to 6 years	2nd MMR, 2nd varicella (chickenpox), ages 4 to 6 years: TB skin test once, booster DTaP, booster polio	Every year

7 to 13 years	Ages 11 to 12: Tdap (tetanus/diphtheria/acellular pertussis); 1st MCV4 (meningococcal conjugate vaccine); HPV (human papillomavirus) vaccine series for females and males ages 11 to 26 years; diabetes and lipid screening for high-risk individuals	Every other year (annually if required for school or sports)
Age	**Vaccination or screening test***	**Checkup**
14 to 21 years	Tdap if not given previously (pregnant women require an extra dose of Tdap to protect their infant), then Td (tetanus/diphtheria) every 10 years; 2nd MCV4 at ages 16 to 18 years, HPV series if not given previously, annual chlamydia test for females if ever sexually active; complete blood count for females (once); diabetes and cholesterol screening for high-risk individuals	Every other year (annually if required for school or sports)

*Vaccine and screening schedule subject to change. These recommended preventive guidelines are subject to change based on the most current evidence and may not reflect what are covered benefits.

SELF-CARE AND RISK COUNSELING FOR ALL AGES

Action	**Age**	**Frequency**
Tobacco use	All	Don't smoke and avoid second-hand exposure
Substance abuse	All	Avoid or quit drug use; limit alcohol
Excessive sun exposure	All	Use a sunscreen daily with a minimum rating of SPF (sun protection factor) 30
Emotional wellness	All	Pay attention to your emotional well-being, plan time for yourself, pace yourself, get enough sleep, and think positive
Physical activity	All	At least 30 to 60 minutes of moderate activity per day, 5 days per week
Diet	All	5 servings of fruit and vegetables a day, plenty of fiber; avoid trans fats and limit saturated fats and sugar.
Injury/accident prevention	All	Always use age-appropriate car restraints; don't drink and drive; always use bicycle/motorcycle/ATV helmets; lock firearms in a safe place
Violence/Abuse	All	Avoid relationships that contain verbal, emotional, physical, or sexual violence
Sexual practices	All	Practice safe sex to avoid HIV and sexually transmitted infections
Pregnancy prevention	All	Always use effective birth control

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PREVENTIVE CARE GUIDELINES FOR ADULTS

Action	Age	Frequency
Vaccinations		
Influenza (flu)	18 years and older	Seasonally
Zoster (shingles)	60 years and older	Once
Td (tetanus/diphtheria)	18 years and older	Once every 10 years
Tdap (tetanus/diphtheria/ acellular pertussis)	18 years and older	Once in place of Td. Pregnant women require an extra dose of Tdap to protect their infant.
Pneumococcus (pneumonia)	19 to 64 years 65 years and older	If high-risk conditions, such as diabetes, asthma, smoking, etc., exist Once, regardless of risk factors
HPV (human papillomavirus) vaccine series for females and males who have not been previously vaccinated	18 through 26 years	Once (series of 3 injections) if not completed previously
Cancer risk screenings		
Colon Cancer		
iFOBT (stool test for blood) Colonoscopy	50 to 75 years	Once a year Every 10 years or more frequently as indicated after discussion with your health care provider
Breast Cancer		
Mammogram	40 to 49 years 50 to 75 years	Consider after discussion with your health care provider Every 1 to 2 years as directed by your physician
Cervical Cancer		
Pap test	21 to 65 years	For ages 21 to 29, every 2 to 3 years; for ages 30 to 65, every 3 to 5 years with HPV co-testing or more frequently if high risk
Prostate Cancer		
PSA with rectal exam	50 years	Consider after discussion with your health care provider
Other preventive services		
Blood pressure	18 years and older	Every 2 years
Lipid evaluation	Men and women age 18	Once if never done before

	Men from 35 years and women from 45 years	Every 5 years or more frequently for higher-risk individuals
Diabetes	45 years	Once every 3 years or more frequently for higher-risk individuals
Bone mineral density test for osteoporosis	65 years	Once
Sexually transmitted diseases		
Chlamydia test	18 to 25 years	Once a year for sexually active women

Kaiser Permanente covers a variety of preventive care services, which are services that do one or more of the following: 1) Protect against disease, such as in the use of immunizations; 2) Promote health, such as counseling on tobacco use; and/or 3) Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer. If you have questions about coverage of medical services mentioned in this grid, please see your *Benefits Summary* or contact Member Services at **1-800-966-5955**.

These recommended preventive guidelines are subject to change based on the most current evidence and may not reflect covered benefits.

PHARMACY SERVICES

Coverage of prescription drugs varies depending upon your benefit plan. If you have a prescription drug benefit, show your Kaiser Permanente ID card when filling prescriptions.

Locations
Pharmacies are located in most of our facilities. You can get prescriptions filled and buy over-the-counter medications and supplies at our pharmacies. In certain instances, you can use select non-Kaiser Permanente pharmacies.

Transfer your prescriptions
For help transferring your prescriptions, call our Care Transition Team at **808-643-5744** Monday–Friday, 9 a.m.–5 p.m. Provide the name and phone number of your current pharmacy and our pharmacy team will take care of the rest.

Prescriptions
Save time by ordering most medications (new and refills) at **kp.org/pharmacycenter** or through your Kaiser Permanente mobile app. Most refills can be mailed to you at no extra cost. And, if you have prescription drug coverage, you can get a 90-day supply of refills for the cost of 60 days for most medications.*

Covered drugs
We use an approved list of drugs to make sure that the most appropriate, safe, and effective prescription medications are available to you. This list is reviewed on a regular basis and includes generic, brand name, and specialty drugs covered under the prescription drug benefit. For more information on covered drugs, visit **kp.org/formulary**.

Drugs not covered

- Nonprescription or over-the-counter medicines
- Drugs for cosmetic uses
- Drugs used for reasons not approved by the FDA
- Plan-excluded prescription drugs

Non-formulary drugs are those that are not included on our drug formulary. Even though non-formulary drugs are generally not covered under our prescription drug benefit plan options, your Kaiser Permanente doctor can request a non-formulary drug for you. If formulary alternatives have failed and use of the non-formulary drug is medically necessary, you may purchase your prescription at your usual drug copayment or receive a refund on prescriptions for which you have already paid full price, provided the drug isn't an exclusion under the prescription drug benefit. Non-formulary drugs are not usually stocked in our pharmacies, so it may take a little longer to have your prescription filled.

If you would like to check on the coverage of a specific drug, or have questions about any limitations on prescribing or access to drugs, contact a pharmacist at any Kaiser Permanente pharmacy.

Contact Us
Pharmacy Services
808-643-RxRx (808-643-7979)

*Kaiser Permanente prescription drug coverage required. We can only mail prescriptions to the States of Hawaii and California at this time. There are restrictions for delivery of certain medications and supplies, including but not limited to controlled medications, injections, medications affected by temperature, and medications excluded by Kaiser Permanente's Pharmacy & Therapeutics Committee.

SPECIALTY CARE

You have access to more than 500 outstanding physicians in over 60 specialties, including Maternity Care, Pediatrics, Orthopedics & Sports Medicine, Cardiology, and Oncology. Our specialists deliver high-quality care and work together to deliver the care you need, when you need it, without barriers. Visit **kp.org/hawaiispecialty** to learn more.

Self-Referrals

You don't need a doctor's referral to make appointments for the following services and departments:

- Allergy
- Eye examinations for glasses and contact lenses
- Family medicine
- Health education
- Internal medicine
- Mental health and wellness
- Pediatrics
- Physical therapy
- Sports medicine

The list of specialties that don't require a referral vary by island. For services not listed above, your doctor may refer you to a specialist when it's medically necessary. Members on Kauai, Molokai, or Lanai may self-refer to contracted network providers, but certain treatments may require a referral. For details, please call Member Services at **1-800-966-5955** (TTY **711**).

HOSPITAL SERVICES

Kaiser Permanente Hawaii's Moanalua Medical Center is a full-service hospital. Integrated and comprehensive quality care is what sets us apart. Our specially trained clinicians and state-of-the-art facility provide medical, surgical, perinatal, neonatal, pediatric, and intensive care for acute illness and injury. The Center also includes an ambulatory surgery and recovery (ASR) department, ambulatory treatment center (ATC), a clinical decision unit for observation stays (CDU), operating rooms, and emergency services.

Admission is based on a physician's review of your medical condition. For planned admissions, such as elective (nonurgent) surgery, the admitting physician will notify you when to report to the hospital. We also work closely with you to plan a smooth and timely discharge.

Neighbor Island Members

Our physicians will direct you to a Kaiser Permanente-designated hospital on your island. This may include Maui Memorial Medical Center, Kona Community Hospital, Hilo Medical Center, North Hawaii Community Hospital, Wilcox Memorial Hospital, West Kauai Medical Center, Sam Mahelona Memorial Hospital, Molokai General Hospital, or Lanai Community Hospital. The need to admit or transfer to the Moanalua Medical Center will be determined by your physician.

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JOINT COMMISSION ACCREDITATION FOR KAISER FOUNDATION HOSPITAL AND OAHU HOME HEALTH

The Joint Commission is an independent, not-for-profit organization founded in 1951. It is dedicated to continuously improving the safety and quality of the nation's health care through the accreditation process.

Organizations voluntarily undergo a survey by a full team of Joint Commission experts every three years. After being surveyed, the organizations are awarded accreditation status if they demonstrate compliance with The Joint Commission's nationally recognized health care standards. Hospitals that choose to be evaluated by The Joint Commission are demonstrating their commitment to providing the highest level of quality care to their patients. The Joint Commission's standards are regarded as the most rigorous in the industry, and its Gold Seal of Approval requires compliance with state-of-the-art standards for quality, safety of care, and other accreditation requirements. Kaiser Foundation Hospital (KFH) – Moanalua has earned The Joint Commission's Gold Seal of Approval™.

The organization was last accredited on April 15, 2015. As an accredited organization, our goal is to provide you with outstanding care. If you have a concern about the quality of care and/or patient safety in the hospital or Oahu Home Health, please contact Hospital Administration. You may find them on the first floor of the hospital, or you can reach them through the hospital operator at **808-432-0000**.

You may contact The Joint Commission's Office of Quality Monitoring at **1-800-994-6610** or by emailing **complaint@jointcommission.org**.

Fax: **630-792-5636**

Or mail to:

TJC - Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

TRAVEL DEPARTMENT

If you live on Maui, Kauai, Molokai, Lanai, or Hawaii Island and need transportation assistance to Oahu for medically necessary care, call our Travel Department:

808-243-6589 (Maui)
1-800-214-6572 (Kauai, Molokai, Lanai, and Hawaii Island)

Monday–Friday, 8 a.m.–5 p.m.
Saturday, 8 a.m.–noon (emergencies only)
Closed Sunday and most holidays
TTY: **711**

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CARE WHILE TRAVELING

Whether you're planning a trip or already away from home, our **Away from Home Travel Line** can help you:

- Find out how to fill an eligible prescription before you leave or while away from home.
- Find care in a Kaiser Permanente region.
- File a claim for reimbursement when you're back.

951-268-3900

This number can be dialed from inside and outside the United States. Outside, you must dial the U.S. country code "001" for land lines and "+1" for mobile before the phone number. Long-distance charges may apply and we cannot accept collect calls. This phone line is closed on major holidays.

You can also visit **kp.org/travel**.

OCCUPATIONAL HEALTH SERVICES (OHS)

While our goal is to help you stay safe and healthy, accidents do happen. When they do, you can be sure that Kaiser Permanente On-the-Job® is here for you.
We have four dedicated Occupational Health Services (OHS) clinics located on Oahu, Maui, and Hawaii Island. Most of our clinics have lab, X-ray, and pharmacy services at the same location, so you won't have to run all over town for follow-up services. Same-day, after-hours, and emergency care are available too.

Kaiser Permanente On-the-Job is a coordinated care program that focuses on your safety and health needs in the workplace. We're here for all employees — not just Kaiser Permanente members, but workers who have chosen other plans too. Our goal is to help you get the care you need so that you can return to work as soon as it's safe for you.

The doctors and nurses at our OHS clinics treat work-related injuries and illnesses daily. If you require further care, we may refer you to one of the many medical specialists available within the Kaiser Permanente network. We also may refer you to a specialist outside of Kaiser Permanente. Because our goal is to give you the time and attention that you deserve, a nurse is available to help guide your treatment through the recovery stages. If you have any questions about your care, contact the OHS clinic coordinator who will assist you.

At Kaiser Permanente On-the-Job, we want to help you stay safe and healthy at work. To help reduce the chances of workplace injuries and illnesses, take advantage of our lifestyle programs offered at our clinics. For more information, call Kaiser Permanente On-the-Job Customer Service:

808-432-2208
1-888-683-2208

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FEE-FOR-SERVICE OFFERINGS

We offer a range of popular services for a fee. These services are not covered by your health plan benefits, but are provided by Kaiser Permanente physicians and staff as support to our community of health-conscious patients.

VISION ESSENTIALS BY KAISER PERMANENTE

Our team of ophthalmologists, optometrists, and opticians are committed to providing high-quality vision services that can improve your quality of life. Our optical centers are conveniently located in our Honolulu, Kailua, Waipio, Kihei, Lahaina, Wailuku, Hilo, and Kona facilities. We offer one-stop vision services, including eye examinations, care for medical conditions (such as glaucoma or cataracts), contact lens fitting services, and a broad selection of competitively priced eyewear. Optical staff members are available to assist you with selection, fitting, and adjustments, and to answer your questions about the latest innovations in frame and lens technology. Most eyeglass repairs and servicing are even done on site. Eyeglass cleaning and adjustments are provided at no charge. To schedule an eye exam online, refill your contact lens order, find out about our latest promotions, and more, visit us at **kp2020.org**.

Contact lens orders:
808-432-2610 (Oahu)
1-866-424-7908 (neighbor islands)
kp2020.org (to order your contact lens refills)

THE VISION CORRECTION CENTER BY KAISER PERMANENTE

LASIK Vision Correction

Schedule a one-on-one consultation with an optometrist to see if you are a candidate for LASIK surgery to correct nearsightedness, farsightedness, or astigmatism. The LASIK fee includes a comprehensive pre-op examination, the LASIK procedure, and all follow-up visits with your surgeon for one year. Enhancement (retreatment) procedures to get you to your best level of vision are included for up to two years. The surgery is performed on Oahu, but neighbor island members have the option of follow-up visits at a Kaiser Permanente facility on their home island.

Premium Intraocular Lens Implants (IOL)

Upgrading to premium IOLs may provide improved range of vision and less dependence on glasses if you have cataracts and are facing surgery to remove them. This optional upgrade is not covered by your health plan benefits or Original Medicare.

1-866-400-1760 for an appointment
Visit us at: **kp.org/visioncenter/hi**
Email us at: **HI.Eyes@kp.org**

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THE AESTHETIC CENTER BY KAISER PERMANENTE

Our Aesthetic Center offers cosmetic skin care and aesthetic surgery services not covered by your health plan benefits. A fee is charged for a consultation, but this fee is deducted from the price of the procedure performed.

1-866-400-1760 for an appointment
Visit us at: **kp.org/aesthetic/hi**
Email us at: **HI.TACPlastics@kp.org**

Cosmetic Skin Care Services
Our cosmetic skin care services vary by location and include:

- State-of-the-art laser treatments for skin resurfacing, photo rejuvenation, brown spot reduction, and permanent hair reduction
- Injectables for wrinkles, including Botox® Cosmetic, Dysport®, Restylane®, Juvederm®, and Sculptra® Aesthetic
- Kybella® treatment for double chins
- Removal of benign skin growths
- Aesthetician services for microdermabrasion, facial peels, skin care products, and complimentary skin evaluations by an aesthetician
- Permanent make-up for eyebrows

Aesthetic Surgery
Our professional team includes experienced surgeons who are recognized leaders in their specialty that perform:

- Breast augmentation or lift
- Tummy tuck and body lift
- Arm and thigh lift
- Liposuction and fat graft
- Facial procedures, including face, neck, eyelids, and brow lifts, as well as nose reshaping and lip augmentation

Surgery is performed primarily on Oahu, but neighbor island members have the option of follow-up visits at a Kaiser Permanente facility on their home island.

THE HEARING SERVICE CENTER BY KAISER PERMANENTE

Ordering and fitting of nationally recognized hearing aids by doctors of audiology are available to members and the general public at our Honolulu, Kailua, Waipio, and Wailuku facilities. Updated assistive listening technology and equipment are also available. Most Kaiser Permanente members typically have coverage for medically necessary hearing examinations. Certain plans include benefits that can cover a portion of the hearing aids. Refer to your *Benefits Summary* for a description of coverage.

1-866-400-1760 for an appointment
Visit us at: **kp.org/hearingservice/hi**
Email us at: **HI.Hear@kp.org**

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ADDITIONAL PLAN INFORMATION

CARE RECEIVED OUTSIDE OF THE KAISER PERMANENTE SYSTEM

The only care from non-Kaiser Permanente practitioners or providers that may be covered is:

- An authorized referral when your Kaiser Permanente physician refers you for care that is not available from Kaiser Permanente.
- Emergency care.
- Out-of-area urgent care when you temporarily travel outside the Hawaii service area.

Outside the Hawaii service area, benefits are limited to authorized referrals (when your Kaiser Permanente physician determines the services you require are not available in the Hawaii service area), emergency benefits, ambulance services, and out-of-area urgent care when you are temporarily away from the Hawaii service area. "Urgent care" means necessary services for a condition that requires prompt medical attention (but is not an emergency medical condition) when:

- You are temporarily away from the Hawaii service area.
- The care is required to prevent serious deterioration of your health.
- The care cannot be delayed until you are medically able to safely return to the Hawaii service area or travel to one of our facilities in another Kaiser Permanente region.

Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered. When you are temporarily traveling outside the Hawaii service area, which consists of the islands of Oahu, Maui, Kauai, Lanai, Molokai, and Hawaii Island, you may require medical services for emergency or urgent problems. Please have your Kaiser Permanente ID card with you at all times. If you're admitted to a hospital, you or a family member must call the toll-free number found on the back of your ID card within 48 hours of your hospital admittance or your claim may be denied.

Services at Kaiser Permanente facilities in our other regions are provided while you're visiting the area for less than 90 days. Visiting member services may be different from the coverage you receive in your home region. Be sure you have your Kaiser Permanente ID card with you at all times. The visiting member program is not a plan benefit but a service offered to members as a courtesy. Changes to the program may occur at any time.

Members who move anywhere outside the Hawaii service area will be terminated. (This does not apply to dependents up to age 26. However, should the subscriber move outside the Hawaii service area, all dependents will be terminated, including dependents up to age 26.) Until your membership is terminated, you'll be covered only for initial emergency care in accordance with your health plan benefits. Before you move outside the Hawaii service area, you should contact your group benefits representative to discuss your options.

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REQUESTS FOR KAISER PERMANENTE SERVICES OR SUPPLIES YOU HAVE NOT RECEIVED

Standard Decision

You, your authorized representative, or treating physician may request that we provide health care services or supplies you have not received but believe you're entitled to receive through Kaiser Permanente. These requests should be submitted in writing to the following address:

Kaiser Foundation Health Plan, Inc.
Authorizations and Referrals Management
2828 Paa St.
Honolulu, HI 96819

808-432-5687 (Oahu and the neighbor islands)

Your written submission should include your name, the authorized representative's name if applicable, your medical record number, the specific service or supply you're requesting, and any comments, records, or other information you think is important for our review. We have the right to require that you provide all documents and information that we deem necessary to make a decision. If you don't provide any information requested in regard to any request for coverage, claim for payment, or related appeal, or if the information you provide does not show entitlement to the coverage or payment you request, this could result in an adverse decision.

You may appoint someone to make this request on your behalf. If you choose to appoint a representative, you must name this person in writing and state that he or she may file the request on your behalf. Both you and your representative must sign and date this statement, unless the person is your attorney. When necessary, your representative will have access to your medical information as it relates to the request. If you prefer, you may call Member Services at **1-800-966-5955** to request an *Appointment of Representative* form.

Our standard decision will be made within 14 calendar days from the date we receive your nonurgent pre-service request. If we cannot make a decision on your request within the standard allotted time because we don't have sufficient information or because of other special circumstances, within the 14 calendar days, we'll send you a written notice of the circumstances requiring an extension of time and the date by which we expect to render a decision. If we determine that your request is not covered, we'll send you a denial notice, which will include the specific reason for the denial, refer to the health plan provisions on which our denial is based, and your appeal rights. If you disagree with our denial decision, you can ask us to reconsider our decision by filing an appeal.

Expedited Decision

You, your authorized representative, or treating physician may ask that we decide your request on an expedited basis if we find, or if your health care provider states, that waiting for a standard decision could seriously affect your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed.

You, your authorized representative, or treating physician may request an expedited decision anytime by calling **808-432-5687**, or by faxing, writing, or delivering your request to the same address listed

for standard decisions. Our fax number is **808-432-5691**. The fax number for appeals is listed in the "How to file an appeal" section on page 13.

Specifically state that you want an expedited decision. If we have all the information we need to make a decision and your request qualifies for expedited review, then we'll give our decision to you orally or in writing within 72 hours of our receipt of your request. If we gave you our decision orally, then we must send you written confirmation within three calendar days following our oral notice.

We will decide your request within 24 hours if we have all the information we need to make a decision when your request relates to an ongoing (sometimes called "concurrent") course of treatment that is being terminated or reduced and you make your request for continued coverage within 24 hours before the services are scheduled to end.

If your request qualifies for expedited review but you don't provide us with sufficient information to determine coverage, we'll inform you within 24 hours of our receipt of your request and give you at least 48 hours to provide us with the specified information. If we decide that your request is not covered, we'll send you a denial notice, which will include the reason for the denial and your appeal rights. If you disagree with our decision, you can ask us to reconsider our decision by filing an appeal, using the appeal procedures described in the "How to file an appeal" section.

You may appoint someone to file your expedited request on your behalf by following the steps described earlier in the "Standard decision" section. If a health care provider with knowledge of your condition makes a request for an expedited decision on your behalf, we don't require you to appoint your health care provider in writing.

FILING A CLAIM

How to File a Claim for Payment

The provider should submit a claim form, including itemized statements describing the services received. We review and authorize claim(s) after the services have been provided, not during an emergency or urgent episode. If you, your family members, or practitioners call us during an emergency or urgent episode, we'll confirm your membership status. However, we will not authorize coverage or payment at that time.

When we receive the claim(s) and medical information, we'll determine whether the services are covered by your Kaiser Permanente plan. Filing a claim does not guarantee payment of that claim. If approved, reimbursement is made to providers according to your health plan benefits.

If you paid for services, you may file a claim by sending your name or the patient's name and medical record number, paid receipt(s), medical documentation, and a written statement describing the sequence of events to the address below within 90 days (or as soon as reasonably possible) after services were received for the out-of-plan emergency or out-of-area urgent care:

Kaiser Foundation Health Plan, Inc.
Attn: Claims Administration
P.O. Box 378021
Denver, CO 80237

After review of your information is completed, the patient or parent can be reimbursed for covered care received from a non-Kaiser Permanente practitioner or provider, less applicable copays/coinsurance, based on:

- Written and authorized referral by a Kaiser Permanente physician.
- Emergency care.
- Out-of-state urgent care when traveling.

If you have questions relating to filing a claim, please contact Member Services at the number listed below. If you have questions specific to a claim already submitted, including the status of your claim, the amount paid, information relating to your cost, or the date the claim was paid, if applicable, please call Claims Administration at **1-877-875-3805**.

You may appoint someone to file the claim on your behalf. If you choose to appoint a representative, you must name this person in writing and state that he or she may file the claim on your behalf. Both you and your representative must sign this statement, unless the person is your attorney. When necessary, your representative will have access to medical information about you that relates to the request. If you prefer, you may call Member Services at **1-800-966-5955** to request an *Appointment of Representative* form.

Claim Decisions

Our standard decision will be made within 30 calendar days from the date we receive your post-service claim for payment. If we don't have sufficient information to make a decision, we'll send you a written notice about the next steps available to you. If we determine that your claim is not covered, we'll send you a denial notice, which will include the specific reason for the denial, refer to the health plan provisions on which our denial is based, and state your appeal rights. If you disagree with our denial decision, you can file an appeal by following the appeal procedures described in the "How to file an appeal" section.

Upon written request to the address listed on page 11 in the "Standard decision" section under the "Requests for services or supplies you have not received" section, you may be provided a free copy of (1) all documents and information relevant to your request for payment or coverage; (2) any rule, guideline, or protocol we relied upon in denying the service or supply you requested; and (3) the identity of any experts whose advice was obtained by us in connection with our denial of your request.

You also have the right to request the diagnosis and treatment codes and their meanings that are the subject of your claim for coverage or payment. You can request this information by calling Claims Administration Member Services at **1-877-875-3805**.

When a health plan like Kaiser Permanente issues an adverse benefit determination, the federal Affordable Care Act requires the health plan to notify recipients of their right to request language assistance to understand the denial notice and their appeal rights. The law also requires health plans to notify recipients of the right to request translation of the denial notice.

Language assistance available in languages mandated by the federal Affordable Care Act:
Para obtener asistencia en Español, llame al 808-432-5955 ó 1-800-966-5955.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 808-432-5955 o di kaya'y 1-800-966-5955.
如果需要中文的帮助，?拨打?个号码 808-432-5955 或者1-800-966-5955。
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 808-432-5955 doodaii 1-800-966-5955.

HOW TO FILE AN APPEAL

Standard Appeal

If we deny your request for payment or coverage, you have the right to file an appeal and ask that we reconsider our decision. Generally, we'll issue a written notice that tells you the specific reasons why we denied coverage or payment for the item or service. The notice will describe your appeal rights and how to file an appeal. You must submit your appeal within 180 days of the date of our denial notice.

You may appoint someone to file the appeal on your behalf. If you choose to appoint a representative, you must name this person in writing and state that he or she may file the appeal on your behalf. Both you and your representative must sign this statement, unless the person is your attorney. When necessary, your representative will have access to medical information about you that relates to the request. If you prefer, you may call Member Services at **1-800-966-5955** to request an *Appointment of Representative* form.

You may file your appeal by mailing or delivering your request to:
Kaiser Foundation Health Plan, Inc.
Attn: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813

Include in your appeal your name, the patient's name and Kaiser Permanente medical record number, the date, the nature of our decision that you're appealing, and all comments, documents, and other information you want us to consider regarding your appeal. Fax your appeal to **808-432-5260** or file it by electronic mail at **KPHawaii.Appeals@kp.org**. If you have questions about the appeals process, you may call Member Services at **1-800-966-5955**.

Standard appeals must be filed on weekdays during office hours, from 7 a.m. to 7 p.m. The receipt date for appeals filed after office hours or on weekends will be the next business day.

When received, your appeal will be prepared for an internal review. Appeal reviews will consider all information you submit (whether or not that information was submitted with your initial request for payment or coverage), will be decided by a different reviewer than the person who denied your initial request, and will not give deference to the initial decision you're appealing. When you appeal, you may give testimony in writing or by telephone. Please call Member Services to get information about giving testimony by phone. If we consider, rely upon or generate any new or additional evidence in our appeal review, or if our appeal decision is based on a new or additional coverage rationale, we will provide you, free of charge, such evidence or coverage rationale as soon as possible and give you a reasonable opportunity to respond before our decision is due. If you do not respond before we must make our decision, our decision will be based on the information that we have on

hand. If we continue to deny your request after our appeal is completed, our written notice to you will include the specific reasons for the decision and refer to the specific plan provisions on which our decision was made. If you are not satisfied with our decision, you may request external review as noted later in this section.

Appeals related to claims for payment (post-service requests) filed by members on employer group plans will be processed through a single level of review. When received, your post-service appeal will be prepared for a review. Generally, we will provide you with our written decision within 60 calendar days. Appeals filed by members on non-group or individual plans (Obtained ON or OFF the Marketplace) will be completed through a single level review and decisions communicated in writing within 60 calendar days of receipt of the appeal.

You may request a free copy of (1) all documents and information relevant to your initial claim and appeal; (2) any rule, guideline, or protocol we relied upon in denying the service or supply you requested; and (3) the identity of any experts whose advice was obtained by us in connection with our denial of your request. You can request the information by calling Member Services at **1-800-966-5955**.

You also have the right to request the diagnosis and treatment codes and their meanings that are the subject of your claim. You can request this information by calling Claims Administration Member Services at **1-877-875-3805**.

When a health plan like Kaiser Permanente issues an adverse benefit determination, the federal Affordable Care Act requires the health plan to notify recipients of their right to request language assistance to understand the denial notice and their appeal rights. The law also requires health plans to notify recipients of the right to request translation of the denial notice.

Language assistance available in languages mandated by the federal Affordable Care Act:
Para obtener asistencia en Español, llame al 808-432-5955 ó 1-800-966-5955.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 808-432-5955 o di kaya'y 1-800-966-5955.
如果需要中文的帮助，?拨打?个号码 808-432-5955 或者1-800-966-5955。
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 808-432-5955 doodaii 1-800-966-5955.

Expedited Appeal

You may ask that we make an expedited decision on your appeal. The expedited procedure applies to denied requests for services or supplies that you have not yet received, or are currently receiving that are being reduced or terminated. It does not apply to denied requests for payment for services or supplies that you have already received. We'll make an expedited decision in less than 72 hours if we find, or if your physician states, that reviewing your appeal under the 30-day process would seriously jeopardize your life or health, seriously affect your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting. Our decision may take longer if we have to wait for information from you or medical records about your case, but we must make a decision within 72 hours of our receipt of such additional information.

You or your physician may request an expedited appeal anytime by calling toll free **1-866-233-2851**, or by faxing, writing, or delivering your request to the same address and phone

numbers listed for standard appeals. If we determine that your request does not meet the criteria for an expedited appeal, we'll automatically review your written appeal under the 30-day process.

Different procedures apply to the following plans: Kaiser Permanente Senior Advantage, Kaiser Permanente Medicare Cost, Kaiser Permanente QUEST Integration, the Federal Employees Health Benefits Program, and Kaiser Permanente Individuals and Families. Members on these plans should consult their respective Evidence of Coverage, handbook, or brochure for a description of the claims and appeals procedures that apply to them.

External Appeal with an Independent Review Organization

Once you've exhausted your internal appeal rights and we've continued to deny coverage or payment as stated in any final adverse benefit determination (ABD) notice that you receive from us, you can request an external appeal with an independent review organization (IRO). The process is available for decisions about medical judgment including one based on our requirements for medical necessity, appropriateness, health care setting, level of effectiveness of care for a covered service, or our determination that the requested care or service is experimental or investigational. If our ABD does not involve medical judgment or medical information, then your request is not eligible for external review through the Hawaii state process.

An IRO is independent from Kaiser Permanente and has the authority to overturn our denial of coverage or payment. The IRO that is responsible for conducting your external appeal is based on your Kaiser Permanente plan.

Our ABD notice will contain information about the IRO that applies to you and instructions on filing an external appeal with the IRO. You may also be able to simultaneously request external review as permitted under federal law in connection with an expedited internal appeal.

If you are covered by a state or county employee plan, certain employee disability, a qualified church plan, or an employee health plan subject to ERISA (the Employee Retirement Income Security Act), then you may have the right to request external review by the Hawaii Insurance Commissioner. You, your appointed representative, or treating provider may file the request for review. Requests for external review must be submitted to the commissioner within 130 days of receipt of Kaiser Permanente's final adverse decision. Requests for external review may be filed at the address below or by facsimile to **808-587-5379**. You can reach the Health Insurance Branch of the Hawaii Insurance Division by calling **808-586-2804**.

State of Hawaii DCCA
Insurance Division - External Appeals
335 Merchant St., 2nd Fl.
Honolulu, HI 96813

If the request is determined eligible for external review, the commissioner will assign the case to an IRO approved by the Insurance Division within three business days. Once assigned, the IRO will notify you and Kaiser Permanente within five business days that the external appeal has been opened for review. We must submit to the IRO within five business days of our receipt of the notice from the IRO all the documents and information that we considered during our internal review of

your request. You or your authorized representative may submit additional written information to the IRO within five business days of your receipt of the notice from the IRO.

The IRO will perform the external review by considering the information noted above and the terms of your Kaiser Permanente plan as well as your medical records, any recommendations from your attending health care professional, additional consulting reports from appropriate health care professionals, the medical necessity statute defined under Hawaii law (Hawaii Revised Statutes chapter 432E-1), the most appropriate practice guidelines, any applicable clinical review criteria developed and used by Kaiser Permanente, and the opinion of the IRO's clinical reviewer. The IRO will not be bound by our initial and appeal adverse decisions in deciding your external appeal. The IRO will send you its decision in writing within 45 days of receiving your external review request. In the event the IRO reverses our adverse decision, we must immediately cover or pay for the service or item that you are requesting.

Expedited External Appeal

Expedited review may be requested from the commissioner by you, your authorized representative, or health care provider if processing under the standard timeframe would result in serious jeopardy to your life or health, seriously affect your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting. Expedited review may also be requested from the commissioner if your appeal involves admission to a facility for health care services, the availability of care or a continued stay at a facility for health care services, or a health care service that you are receiving during an emergency visit before you are discharged from the facility where the emergency services are being obtained. If your request qualifies for expedited processing at the time you receive our initial ABD or file your internal appeal, you have the right to simultaneously request expedited review with the commissioner. The expedited process does not apply to services or items that you have already received.

If the request is determined eligible for expedited external review, the commissioner will immediately assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must transmit to the IRO in an expeditious manner all the documents and information that we considered during our internal review of your request.

The IRO will perform the external review by considering the same types of information as noted earlier under the standard process. The IRO will not be bound by our initial and appeal adverse decisions in deciding your external expedited appeal. The IRO will notify you of its decision as expeditiously as your medical condition or the circumstances require, but in no event more than 72 hours of its receipt of your eligible expedited request. If its decision was provided verbally at first, then the IRO must send written confirmation within 48 hours of its verbal notice. In the event the IRO reverses our adverse decision, we must immediately cover or pay for the service or item that you are requesting.

External Review Requests for Experimental or Investigational Services or Treatments

Additional procedures apply to a request involving an experimental or investigational service or treatment. You or your authorized representative may make an oral request for expedited review if your treating physician certifies in writing that the service or treatment you are requesting would be significantly less effective if it was not initiated promptly. This certification must be filed promptly

with the commissioner following your oral request for review. If you or your authorized representative request expedited review in writing rather than orally, you must include your treating physician's written certification with the written request. If your request is determined eligible for expedited review, the commissioner must immediately assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must transmit to the IRO in an expeditious manner all the documents and information that we considered during our internal review of your request.

Within three business days after being assigned to perform the external review, the IRO will select one or more clinical reviewers who are experts in the treatment of the condition and knowledgeable about the service or treatment that is the subject of the request. Each clinical reviewer must provide an opinion regarding whether the service or treatment should be covered. This opinion must be provided to the IRO orally or in writing as expeditiously as your condition requires but in no event more than five calendar days after the reviewer was selected. If the opinion was provided orally, then the reviewer must provide a written report to the IRO within 48 hours following the date the oral opinion was provided. The IRO must provide you, your authorized representative, and Kaiser Permanente with its decision either orally or in writing within 48 hours after it receives the opinion. If its decision was provided orally, then the IRO must send its decision in writing within 48 hours of the oral notice. If a majority of the clinical reviewers recommend that the service or treatment should be covered, then the IRO must reverse Kaiser Permanente's adverse decision. If a majority of the reviewers recommend that the service or treatment should not be covered, then the IRO will make a decision to uphold Kaiser Permanente's adverse decision. If the reviewers are evenly split as to whether the service or treatment should be covered, then the IRO must obtain the opinion of another clinical reviewer. The processing timeframes are not extended if the IRO needs to obtain the opinion of an additional reviewer.

For non-expedited requests involving an experimental or investigational service or treatment that are determined eligible for external review, the commissioner has three business days after the eligibility decision was made to assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must submit to the IRO within five business days of our receipt of the name of the IRO all the documents and information that we considered during our internal review of your request. You or your authorized representative may submit additional written information to the IRO within five business days of your receipt of the Insurance Division's notice that your case was assigned to an IRO. The IRO must select one or more clinical reviewers within three business days after it was assigned to perform the external review. Each reviewer must provide its opinion to the IRO in writing within 20 days of the date the IRO was assigned to perform the review. The IRO must then provide its written decision to you, your authorized representative, and Kaiser Permanente within 20 days after the opinions were received. The IRO must decide to reverse or uphold Kaiser Permanente's adverse decision in the same manner discussed earlier based on a majority of the clinical reviewers' recommendations.

Procedures Applicable to All Requests for External Review

The IRO's decision is binding on you and Kaiser Permanente except for any additional remedies that may be available to you or Kaiser Permanente under applicable federal or state law. You or your authorized representative may not file a subsequent request for external review involving the same adverse decision for which you already received an external decision.

When filing any request for external review, you must include a copy of Kaiser Permanente's final ABD with your request, unless you are seeking simultaneous expedited external review or we have substantially failed to comply with our internal appeals procedures. You or your authorized representative will also be required to authorize the release of your medical records that need to be reviewed for the external appeal, as well as provide written disclosure that permits the commissioner to perform a conflict of interest evaluation as part of the selection process for an appropriate IRO. You can find forms that meet each requirement on our website at **kp.org** or by calling Member Services at **1-800-966-5955**. Lastly, a $15 filing fee must be included with the external appeal request. The filing fee will be refunded if Kaiser Permanente's adverse determination is reversed through the external review or the commissioner waives the fee because it poses an undue hardship on you. Your request will be considered incomplete and the external review delayed if you do not submit all the required information with the request.

When you submit a request for external review, the commissioner will inform Kaiser Permanente about your request. We will be responsible for notifying the commissioner and you or your authorized representative in writing whether the request is complete and eligible for external review. If we believe your request is not eligible for external review, you may file an appeal with the commissioner. Our notice of ineligibility will include information on requesting this appeal.

You must exhaust Kaiser Permanente's internal claims and appeals process before you may request external review, except (1) when external review is permitted to occur simultaneously for requests that qualify for expedited review, or (2) we have failed to comply with applicable claims and appeals requirements under federal or state law. You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures and external review. If you are enrolled through a plan that is subject to ERISA, you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-3272**. Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

Different procedures apply to the following plans: Kaiser Permanente Senior Advantage, Kaiser Permanente Medicare Cost, Kaiser Permanente QUEST Integration, and the Federal Employees Health Benefits Program. Members on these plans should consult their respective Evidence of Coverage, handbook, or brochure for a description of the independent external review procedures that apply to them.

BINDING ARBITRATION

Except as provided below, any and all claims, disputes, or causes of action arising out of or related to the service agreement, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

This includes but is not limited to any claim asserted:

(a) By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the member or patient as permitted by applicable federal or

Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this service agreement, all family members of the member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;

(b) On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under the service agreement, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and

(c) By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):

(i) Kaiser Foundation Health Plan, Inc.,
(ii) Kaiser Foundation Hospitals,
(ii) Hawaii Permanente Medical Group, Inc.,
(iii) The Permanente Federation, LLC,
(iv) The Permanente Company, LLC,
(v) Any individual or organization that contracts with an organization named in (i), (ii), (iii), (iv) or (v) above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

Notwithstanding any provisions to the contrary in the service agreement, the following claims shall not be subject to mandatory arbitration:

(a) claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
(b) actions for appointment of a legal guardian of a person or property subject to probate laws;
(c) purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services under the service agreement (such as temporary restraining orders, and emergency court orders).
(d) for members of Groups, claims for benefits under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA); and equitable claims for third party liability lien rights under Section 502(a)(3) of ERISA;

Initiating Arbitration

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at the address set forth in the service agreement. The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration Proceedings

1. Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

2. Within 30 calendar days after notice to Dispute Prevention and Resolution, Inc., the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

3. Limited civil discovery shall be permitted only for
    (a) production of documents that are relevant and material,
    (b) taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and
    (c) independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

4. Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties.

5. Each party shall bear their own attorney's fees, witness fees, and discovery costs.

6. The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

7. In claims involving benefits and coverage due under the service agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review.

8. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial.

9. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

Confidentiality

The arbitration proceeding concerns personal medical information whose confidentiality is protected by law. Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

Special Claims

1. **Medical Malpractice Claims.** Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. If the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified above.

2. **ERISA Claims.** If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may request external review, as discussed below, and/or file suit in federal court under Section 502(a)(1)(B) of ERISA. If a suit is filed, the court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact the plan administrator, i.e., the Member Party's employer or group sponsor.

   Although benefit-related claims subject to ERISA are not required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of section Initiating Arbitration above. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to this Binding Arbitration section.

3. **External Appeal of Internal Adverse Benefit Decisions**. If Member disagrees with Kaiser Permanente's final internal determination, Member shall request binding arbitration pursuant to the procedures Kaiser Foundation Health Plan, Inc.'s Group

Medical and Hospital Service Agreement subject to Section 8.F.2 regarding ERISA claims. In addition to the arbitration procedures set forth in the Service Agreement, Hawaii Revised Statutes Chapter 432E also creates certain external review rights for Members of state or county employee Groups, certain employee disability or qualified church plans, and employer Groups subject to ERISA to submit a request for external review to the State Insurance Commissioner within one hundred thirty days from the date of Kaiser Permanente's final internal determination. These rights are subject to the limitations noted at the end of this subsection, and subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhaustion of Kaiser Permanente's internal claims and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals procedures is described in this Handbook.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. An adverse action is a Health Plan determination that a health care service that is a covered benefit has been reviewed and denied, reduced or terminated because it does not meet Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. Health Plan objects to external reviews under Chapter 432E which do not meet these criteria and reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.

General Provisions

All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in the service agreement in any particular case, then such term(s) shall be severable in that case and the remainder of the service agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple members or patients are prohibited.

KAISER PERMANENTE®

THIRD-PARTY LIABILITY

Kaiser Permanente has the right to recover the cost of care for a member's injury or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the member by an insurance company, individual, or other third party.

UTILIZATION MANAGEMENT

The medical care and services provided or authorized by a physician are subject to utilization management (UM) review. UM describes the methods we use to ensure you receive the right care at the right time in the right place.
We use the advice and cooperation of practitioners and providers to ensure quality, cost-effective care for members. Some of these services, which we continuously monitor and evaluate, are:

- Review of hospital admissions
- Review of referred services
- Review of post-service claims
- Case management services for certain medical conditions to help members maintain their health at the highest level possible
- Clinical practice guidelines

If, at any time, you feel you are not receiving coverage for an item or service that you believe is medically necessary, you have the right to make a request for services or supplies you have not received, or to file a claim for payment of charges you've incurred. If you don't agree with our decision regarding your request, you have the right to request an appeal.

Kaiser Permanente physicians, practitioners, employees, and affiliated physicians and practitioners (professionals contracted with Kaiser Permanente) who make decisions about your medical treatments and services have a primary focus on providing the level of care that is appropriate for your needs. All UM decision-making is based on evidence that service and care are medically necessary, appropriate, and covered by your plan. There is no reward for denying care and no financial incentives that encourage denial of service or coverage that may result in underutilization. Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating practitioners or other individuals based on the likelihood that the individual would (or tends to) support the denial of benefits.

For any UM inquiries during regular business hours, please call Member Services Monday through Friday, 8 a.m. to 5 p.m., or Saturday, 8 a.m. to noon:

1-800-966-5955
711 (TTY for the hearing/speech impaired)

After regular business hours and holidays:

808-432-7100 (Oahu)
1-800-227-0482 (neighbor islands, toll free)

Language assistance services are provided free of charge for members through an interpreter.

Bilingual Access Line: 808-526-9724

After regular business hours, your message will be forwarded to our UM team and your call will be returned the next business day. You may also fax us at **808-432-7419**.

YOUR RIGHTS AND RESPONSIBILITIES

You are our partner in your health care, and your participation in decisions about your health care is important. Your willingness to speak with your doctor and other health care practitioners about your needs can help us provide you with the right type of care.

For detailed information about your rights to privacy, please refer to your Notice of Privacy Practices on our website at **kp.org**. Simply click on the "Privacy" link at the bottom of the page, and then click on the "Notice of Privacy Practices" link. Or contact Member Services at **1-800-966-5955**.

YOUR RIGHTS

As a person using our services, you have specific rights regardless of your age, cultural background, gender, gender identity, sexual orientation, financial status, national origin, race, religion, or disability.

For detailed information about member rights to privacy, please refer to our Notice of Privacy Practices. You can find the Notice of Privacy Practices on our website at **kp.org**, or contact Member Services at **1-800-966-5955** (711 TTY hearing/speech impaired).

You have a right to:

- Receive information about Kaiser Permanente, our services, our health care practitioners and providers, and your rights and responsibilities.
- Get information about the people who provide health care, including their names, professional status, and board certification.
- Be treated with consideration, compassion, and respect, taking into account your dignity and individuality, including privacy in treatment and care.
- Be free from neglect, exploitation, and verbal, mental, physical and sexual abuse.
- Make decisions about your medical care. This includes advance directives to have life-prolonging medical or surgical treatment given, ended, or stopped, withholding resuscitative services, and care at the end of life. You have the right to assign another person to make health care decisions for you, to the extent allowed by law.
- Discuss all medically necessary treatment options, regardless of cost or benefit coverage.
- Voice your complaints or appeals about Kaiser Permanente or the care we provide freely without fear of discrimination or retaliation. If you are not satisfied with how your complaint was handled, you may have us reconsider your complaint.
- Make recommendations regarding Kaiser Permanente's member Rights and Responsibilities statement.

- Be involved and include your family in the planning of your medical care. You have the right to be informed of the risks, benefits, and consequences of your actions. You may refuse to participate in research, investigation and clinical trials.
- Choose your primary care physician, change your primary care physician, or obtain a second opinion within Kaiser Permanente. You also have the right to consult with a non-Plan doctor at your expense.
- Establish a relationship with a specialist or qualified practitioner of women's health services to assure your continuing care.
- Receive information and discuss with your doctor your medical condition, available treatment options, alternatives, and diagnosis in a manner appropriate to your condition and your ability to understand.
- Obtain language interpretation services when required to understand your care and services.
- Be involved in the consideration of bioethical issues. You have the right to contact our Bioethics Committee for help in resolving ethical, legal, and moral matters relating to your care.
- Be informed of the relationship between Kaiser Permanente and other health care programs, providers, and schools.
- Be informed about how new technologies are evaluated in relation to benefit coverage.
- Receive the medical information and education you need to participate in your health care.
- Give informed consent before the start of any procedure or treatment.
- Give or withhold informed consent to produce or use recordings, films, or other images of you for purposes other than your own care.
- Have access to medically necessary services and treatment, including emergency treatment, and covered benefits, in a timely and fair way. Services should not be arbitrarily denied or reduced in amount, duration, or scope because of diagnosis, type of illness, or condition.
- Receive services in a coordinated manner. Your PCP is in charge of your medical care. He or she treats you, refers you to specialists when needed, and connect you to all of our services. Your doctor will work with you to help you meet your health goals so that you can live well.
- Have your cultural, psychological, social, and spiritual needs considered and respected.
- Be assured of privacy and confidentiality of all communications and records related to your care and have your confidentiality protected. You or a person of your choosing can request and receive a copy of or access your medical records and request to amend or correct the record, within the limits of the law. In addition, you have the right to limit, restrict, or prevent disclosure of PHI.
- Be treated in a safe, secure, and clean environment free from physical and drug restraints except when ordered by a doctor, or in the case of an emergency, when it is necessary to protect you or others from injury.
- Receive appropriate and effective pain management as an important part of your care plan.
- Get an explanation of your bill and benefits regardless of how you pay. You have the right to know about our available services, referral procedures, and costs.

- Receive other information and services required by various state or federal programs.
- When appropriate, be informed about the outcomes of care, including unanticipated outcomes. Be informed of the ability to change providers if other qualified providers are available.
- Discuss "do not resuscitate" wishes or advance directive instructions for health care with your surgeon and anesthesiologist prior to an operative procedure when you wish to have the "do not resuscitate" honored in the event of a life-threatening emergency during an operative procedure.

Medicaid patients receiving services, including in the Ambulatory Surgery Center, who wish to file a complaint or voice a concern may contact the Medicaid Ombudsman, Hilopaa, at www.hilopaa.org, or by calling **1-808-791-3467** (Oahu) or **1-808-270-1536** (Maui). Medicare patients may contact the Office of the Medicare Beneficiary Ombudsman at www.medicare.gov.

The patient receiving services in the Ambulatory Surgery Center may also contact Accreditation Association for Ambulatory Health Care; 5250 Old Orchard Road, Suite 200, Skokie, IL 60077. Tel: **847-853-6060**, Fax: **847-853-9028**, or by email: info@aaahc.org.

YOUR RESPONSIBILITIES

As a partner in your health care, you have the following responsibilities:

- Provide accurate and complete information about your present and past medical condition.
- Follow the treatment plan agreed on by you and your health care practitioner. You have a responsibility to inform your health care practitioner if you do not understand or cannot follow through with your treatment.
- Understand your health problems and participate in developing mutually agreed upon treatment goals, to the extent possible.
- Identify yourself appropriately and use your Kaiser Permanente identification card in accordance with our policies and procedures.
- Cooperate with our staff to help ensure proper diagnosis and treatment of your illness or condition.
- Keep your appointments, or if you cannot keep them, cancel appointments in a timely manner.
- Know your benefit coverage and its limitations.
- Cooperate in signing a release form when you choose to refuse recommended treatment or procedures.
- Realize the effects your lifestyle has on your health and understand that decisions you make in your daily life, such as smoking, can affect your health.
- Be considerate of others by respecting the rights and feelings of the staff, and respecting the privacy of other patients.
- Refrain from disturbing or disrupting operations and administration, and cooperate with staff to allow services to other patients to be performed without interruption.

- Follow all hospital, clinic, and health plan rules and regulations, including respecting hospital visiting hours.
- Cooperate in the proper processing of third-party payments.
- Inform us when you or your covered dependents change addresses or other contact information.
- Be responsible for your actions. If you refuse treatment or do not follow instructions, or your action or behavior interferes with facility and/or patient care, your care may be rescheduled. Should your medical condition change, the treatment plan may be modified.
- For Ambulatory Surgery Center (ASC) patients, provide a responsible adult to transport you home from the ASC and remain with you for 24 hours, if required by your provider.

PATIENT SAFETY

Kaiser Permanente is committed to being a national leader in patient safety. We strive to provide care that is reliable, effective, consistent, and safe. We believe that patient safety is every patient's right and every person's responsibility.

At the forefront of patient safety is Patient and Family Centered Care, assuring participation, information sharing, collaboration, dignity, and respect for our patients, members, and their families. Throughout Kaiser Permanente, we'll continue to implement activities broadly aimed at achieving the following ideals:

- **Safe Culture**: Create and maintain a strong, unified patient safety culture, with patient safety and error reduction embraced as shared organizational values. Part of creating a safe culture is developing a safe reporting system that invites staff to report near misses and close calls.
- **Safe Communication:** Strong safety teams foster safe communication that allows staff to speak up.
- **Safe Practices:** Standardization is an important part of error reduction. Standardization should be part of safety concepts and should be incorporated into everything we do every day.
- **Safe Care**: Ensure that the actual and potential hazards associated with high-risk procedures, processes, and patient care populations are identified, assessed, and controlled in a way that demonstrates continuous improvement and moves the organization toward the ultimate objective of ensuring our patients' freedom from accidental injury or illness.
- **Safe Staff**: Ensure that our staff has the knowledge and competence to safely perform required duties and improve system safety performance.
- **Safe Support Systems**: Identify, implement, and maintain support systems, including advisory councils and families, that provide the right information to the right people at the right time. This includes responsible reporting.
- **Safe Place**: Design, construct, operate, and maintain the environment of care as well as evaluate, purchase, and utilize equipment and products in a way that enhances the efficiency and effectiveness with which safe health care is provided.
- **Safe Patients**: Engage and partner with patients and their families in reducing medical errors and improving overall system safety performance. It's important that you take an active role in ensuring your own patient safety. Here are some ways you can work with your medical team to help keep yourself safe when visiting our medical offices or as a patient in the hospital.
- **Ask questions**: It's OK to ask questions and to expect answers you can understand.

- **Know the members of your medical team**: All health care professionals must wear identification badges. Don't hesitate to ask them to show their identification badges.
- **Wash your hands**: Hand washing prevents the spread of infections. Wash your hands after you move around the room, touch things, or use the bathroom. Don't hesitate to ask your medical team and visitors if they have washed their hands.
- **Share important health information with your medical team**: Several staff members may ask you the same questions — that's OK. It's part of making sure you receive safe care. Discuss all of the medications you're taking, including herbal and over-the-counter medications.
- **Know how to use your medications**: If you don't understand why you're taking a medicine, ask. Ask about side effects and what food or drinks to avoid when taking any medication. Read the labels and all warnings. Make sure that it's the medication ordered for you and that you know what to expect.
- **Make sure that you're receiving the correct treatment**: Make sure that all staff members check your identification wristband (if in the hospital) when you receive medication or treatments. When visiting our medical offices, make sure staff members check your name and birth date. Bringing proper identification, including a photo ID, helps to ensure that we have the correct member when registering you for services.
- **Get all your test results**: Don't assume that the results of your test are OK — always ask for your results. Ask when and how you can expect to receive them.
- **Before you leave the medical offices or hospital**: Make sure you know what you need to do next and who to contact if you have questions.
- **Always carry a list of your current medications with you**: Make sure that you keep an updated list of your medications with you, including the doses and how often you're taking each one. When you're admitted to the hospital, your health care team can make sure that your medications don't interfere with your current treatment and won't interact with other medications. Make sure you also list any over-the-counter and herbal medications.

If you have concerns about patient safety or quality of care while in the hospital or home health facility: please speak with the physician in charge or ask for the department manager. If you still have concerns, please contact Hospital Administration. You may find them on the first floor of the hospital, or you can reach them through the hospital operator at **808-432-0000**.

You may contact The Joint Commission's Office of Quality Monitoring at **1-800-994-6610** or by email: **complaint@jointcommission.org**
Fax: **630-792-5636**

Or mail to:
TJC - Office of Quality Monitoring
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

HOSPITAL PATIENT RIGHTS

As a person receiving our services, you have specific rights regardless of your age, cultural background, gender, gender identity, sexual orientation, financial status, national origin, race, religion, or disability.

As a patient in the Moanalua Medical Center, you also have the right to:

- Receive information about your rights and responsibilities when you are admitted.
- Receive orderly transfer and discharge for your welfare, for other patients' welfare, or other causes as determined by your physician. Also, you have the right to receive reasonable advance notice and discharge planning by qualified hospital staff to help ensure appropriate post-hospital placement and care.
- Request visits by clergy at any time and participate in social and religious activities, unless doing so infringes on the rights of other patients or would compromise your medical care.
- Receive and use your own clothing and possessions as space permits, unless doing so infringes on the rights of other patients, is in violation of hospital safety practices, or would compromise your medical care.
- Give informed consent before the start of any recording, films, or other images for purposes of non-patient care.
- Access protective and advocacy services.
- Access appropriate educational services when a child or adolescent patient's treatment necessitates a significant absence from school.
- Protection from requests to perform services for Kaiser Foundation Hospital that are not included for therapeutic purposes in your plan of care.
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation as specified in federal regulations on the use of restraints and seclusion.
- Receive visitors of your choice including a spouse, (same-sex) domestic partner, family member, or friend. All or certain visits may be excluded at your request or discretion of staff, physicians, or administration to allow for your and others' rights, safety, or well-being.
- File a complaint in the hospital, either verbally or in writing, with the department manager or supervisor. If you are not satisfied with the response, you may contact Hospital Administration, which is located on the first floor of the hospital or reached through the operator at **808-432-0000**.
- You may also contact The Joint Commission (an independent nonprofit organization that accredits and certifies health organizations and programs) by phone, mail, fax, or email. Phone: Toll free U.S., Weekdays 8:30 a.m.–5 p.m. Central time, **1-800-994-6610**. Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. Fax: **630-792-5636**. Email: **complaint@jointcommission.org**.

MEMBER SATISFACTION PROCEDURE

We welcome your comments and concerns. They are an encouragement when we meet your expectations and an opportunity for improvement when we fall short. You may provide your comments and concerns to your personal physician or the departmental supervisor. You may also use the Let Us Hear From You customer feedback forms found in all Kaiser Permanente facilities, or call or write to Member Services. We'll respond within 30 days of receiving your comments and concerns.

Our address
Kaiser Foundation Health Plan, Inc.
Member Services
711 Kapiolani Blvd.
Honolulu, HI 96813

1-800-966-5955
711 (toll free) TTY hearing/speech impaired

KAISER PERMANENTE®

ABOUT QUALITY CARE

Each year, Kaiser Permanente produces a quality summary report that identifies the goals, objectives, and activities we use to improve care and service to members and our community. For a free copy of this report, please call Member Services at **1-800-966-5955**. You may also view the report on our website at **kp.org/quality.**

PRIVACY INFORMATION

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws.

We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes such as quality assessment and improvement, customer service, and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose certain PHI to them, such as information regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes, we contract with others (business associates) to perform services for us and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information about your right to see, correct, update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI, which we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our Notice of Privacy Practices, which is available on our website **kp.org/hawaii/privacy-practices**, in our medical offices, or by calling Member Services. If you have questions or concerns about our privacy practices, please contact Member Services at **1-800-966-5955** or **711** (TTY hearing/speech impaired).

NEW MEDICAL TECHNOLOGIES

Doctors depend on research and advances in science to give their patients a better and sometimes longer life. Our Interregional New Technologies Committee, made up of physicians and scientists from across Kaiser Permanente nationwide, studies medical advances to ensure they are tested, safe, and helpful. By continually reviewing medical advances and our benefit coverage, we strive to provide advanced, effective, and efficient medical care. If you would like to know more about the review process for medical technologies in relation to benefit coverage, please call Member Services at **1-800-966-5955**.

MASTECTOMY-RELATED COVERAGE

Under the Women's Health and Cancer Rights Act of 1998, we are required to annually notify members of our health plan's obligation to provide the following coverage after a mastectomy, as determined in consultation with the attending physician and the patient:

- Reconstruction of the breast(s) on which the mastectomy was performed.
- Surgery and reconstruction of the breast(s) to produce a symmetrical (balanced) appearance.
- Prosthesis (artificial replacement).
- Services for physical complications resulting from the mastectomy.

Coverage is subject to your plan's supplemental charges. If you have any questions, please call Member Services at **1-800-966-5955**.

ADVANCE HEALTH CARE DIRECTIVE

At Kaiser Permanente Hawaii, we support your right to make decisions regarding your health care, and we want to know how to manage your health care when you can no longer tell us. In fact, we encourage you to make these important decisions now, when you're healthy. With an advance health care directive, you can take charge of your health care and help ensure that your wishes will be respected.

By putting your wishes in writing, you can be sure that your family and health care team will know your preferences if you become unable to make decisions for yourself. By clarifying your wishes when you're able to think clearly about them, you free your family from having to make difficult decisions for you. Your completed document(s) will be available 24 hours a day from Kaiser Permanente.

If you want more information or to request a forms packet, please contact Member Services at **1-800-966-5955** or **711** (TTY hearing/speech impaired).

MEDICARE ELIGIBILITY

Medicare is the federal health insurance program for people ages 65 or older, some people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (ESRD), which is permanent kidney failure requiring dialysis or kidney transplant.

When you reach 65 or become eligible for Medicare, a change in your premium may occur. You may continue your Kaiser Permanente membership in addition to Original Medicare or you may be eligible for enrollment in Kaiser Permanente Senior Advantage (HMO), our Medicare Advantage plan. Prospective Senior Advantage plan enrollees must reside in the Senior Advantage Hawaii service area of Oahu, Maui, and Hawaii (except for ZIP codes 96718, 96772, and 96777).

To obtain information about your eligibility under Original Medicare, visit **medicare.gov** or call: **1-800-MEDICARE (1-800-633-4227)**.

For more information about whether or not you qualify to enroll in Senior Advantage, call Senior Advantage Plan Member Services at **1-800-805-2739,** 8 a.m. to 8 p.m., 7 days a week. TTY only, call 711.