**January 1–December 31, 2018**

# 2018
# Summary of benefits

## Kaiser Permanente Senior Advantage (HMO) Group plan for

### City and County of San Francisco

With Medicare Part D prescription drug coverage

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KAISER PERMANENTE®

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# Summary of Benefits

Thank you for considering Kaiser Permanente Senior Advantage. You can use this **Summary of Benefits** to learn more about our plan. It includes information about:

- Benefits and costs
- Part D prescription drugs
- Who can enroll
- Coverage rules (including referrals and prior authorizations)
- Getting care

For definitions of some of the terms used in this booklet, see the glossary at the end.

# For more details

This document is a summary. It doesn't include everything about what's covered and not covered or all the plan rules. For details, see the **Evidence of Coverage (EOC)**, which we'll send you after you enroll. If you'd like to see it before you enroll, please ask your group benefits administrator for a copy.

**Have questions?**
- Please call Member Services at **1-800-805-2739** (TTY **711**).
- 7 days a week, 8 a.m. to 8 p.m.

# What's covered and what it costs

| Benefits and premiums | You pay |
|---|---|
| **Monthly plan premium** | Your group will notify you if you are required to contribute to your group's premium. If you have any questions about your contribution toward your group's premium and how to pay it, please contact your group's benefits administrator. |
| **Deductible** | **None.** |
| **Your maximum out-of-pocket responsibility**<br>Doesn't include Medicare Part D drugs. | **$2,500** |
| **Inpatient hospital coverage**<br>There is no limit to the number of medically necessary inpatient hospital days. | •**$50 copay** per day for days 1 through 6.<br>•**$0** per day for days 7 and beyond. |
| **Outpatient hospital coverage** | **$50** per surgery |
| **Doctor's visits**<br>• Primary care providers<br>• Specialists<br><br>**Preventive care**<br>See the **EOC** for details. | <br>**$20** per visit.<br>**$20** per visit.<br><br>**$0** |
| **Emergency care**<br>We cover emergency care anywhere in the world. | **$75** per Emergency Department visit. |
| **Urgently needed services**<br>We cover urgent care anywhere in the world. | **$20** per office visit |
| **Diagnostic services, lab, and imaging**<br>• Lab tests | **$0** |
| • Diagnostic tests and procedures (like EKG) | **$0** |
| • X-rays | **$20** per X-ray. |
| • Other imaging procedures (like MRI, CT and PET) | **$20** per test. |
| **Hearing services**<br>• Exams to diagnose and treat hearing and balance issues<br>• Routine hearing exams | **$20** per visit. |

| Benefits and premiums | You pay |
|---|---|
| **Dental services**<br>Preventive and comprehensive dental coverage | Not covered unless your group has purchased a dental rider (if applicable, see dental rider attached in the back). |
| **Vision services**<br>• Visits to diagnose and treat eye diseases and conditions | **$20** per visit. |
| • Routine eye exams | **$20** per visit. |
| • Eyeglasses or contact lenses after cataract surgery | **20%** coinsurance up to Medicare's limit and you pay any amounts beyond that limit. |
| • Other eyeglasses or contact lenses | Not covered unless your group has purchased an optical rider (if applicable, see optical rider attached in the back). |
| **Mental health services**<br>• Outpatient group therapy | **$20** per visit. |
| • Outpatient individual therapy | **$20** per visit. |
| **Skilled Nursing Facility**<br>Our plan covers up to 100 days per benefit period. | **Per benefit period:**<br>**$0** per day for days 1 through 20.<br>**$50** per day for days 21 through 100. |
| **Physical therapy** | **$20** per visit. |
| **Ambulance** | **20% coinsurance** per one-way trip. |
| **Transportation** | Not covered. |
| **Wellness programs**<br>Fitness benefit: Silver&Fit® fitness programs, including a basic facility membership. | **$0** |
| **Medicare Part B drugs**<br>A limited number of Medicare Part B drugs are covered when you get them from a plan provider (see the **EOC** for details.)<br>• Drugs that must be administered by a health care professional | **20%** coinsurance. |
| • Up to a 30-day supply from a plan pharmacy | • **$12** for generic drugs<br>• **$45** for brand-name drugs. |

# Medicare Part D prescription drug coverage

The amount you pay for drugs will be different depending on:

- The tier your drug is in. To find out which of the six tiers your drug is in, see our Part D formulary at **kp.org/seniorrx** or call Member Services to ask for a copy at **1-800-805-2739**, 7 days a week, 8 a.m. to 8 p.m.**(TTY 711)**.
- Your drug quantity (like a 30-day or 90-day supply). Note: A 90-day supply isn't available for all drugs.
- When you get a 90-day supply, whether you get your prescription filled by one of our retail plan pharmacies or our mail-order pharmacy. Note: not all drugs can be emailed.
- The coverage stage you're in (initial, coverage gap, or catastrophic coverage stages).

## Initial Coverage Stage

You pay the copays and coinsurance shown in the chart below until your total yearly drug costs reach **$3,750**. Total yearly drug costs are the amounts paid by both you and any Part D plan during a calendar year. If you reach the $3,750 limit, you move on to the coverage gap stage and your coverage changes.

| Tier | You pay |
|---|---|
| **Tier 1 (Preferred Generic)** | **$3 (up to a 30-day supply)** |
| **Tier 2 (Generic)** | **$15 (up to a 30-day supply)** |
| **Tier 3 (Preferred Brand)** | **$50 (up to a 30-day supply)** |
| **Tier 4 (Nonpreferred Brand)** | **$50 (up to a 30-day supply)** |
| **Tier 5 (Specialty Tier)** | **$200 (up to a 30-day supply)** |
| **Tier 6 (Vaccines)** | **$0** |

When you get a **31- to 90-day supply** you will pay the following for drugs in Tiers 1-5:

- If you get a 31- to 60-day supply from a plan pharmacy (retail or mail order), you pay 2 copays.
- If you get a 61- to 90-day supply from a plan pharmacy (retail or mail order), you pay 3 copays.
- If you get a 61- to 60-day supply from our mail-order pharmacy, you pay 2 copays.

## Coverage gap and catastrophic coverage stages

The coverage gap stage begins if you or a Part D plan spends $3,750 on your drugs during 2018. You pay the following copays and coinsurance during the coverage gap stage:

| Tier | You pay |
|---|---|
| **Tier 1 (Preferred Generic)** | **$3** (up to a 30-day supply) |
| **Tier 2 (Generic)** | **$15** (up to a 30-day supply) |
| **Tier 3 (Preferred Brand)** | **$50** (up to a 30-day supply) |
| **Tier 4 (Nonpreferred Brand)** | **$50** (up to a 30-day supply) |
| **Tier 5 (Specialty Tier)** | **$200** (up to a 30-day supply) |
| **Tier 6 (Vaccines)** | **$0** |

If you spend **$5,000** on your Part D prescription drug costs in 2018, you'll enter the catastrophic coverage stage. Most people never reach this stage, but if you do, your copays and coinsurance will change for the rest of the year. To find out what you would pay during this stage, see the **Evidence of Coverage**.

## Long-term care and non-plan pharmacies

If you live in a long-term care facility and get your drugs from their pharmacy, you pay the same as at a plan pharmacy and you can get up to a 31-day supply. If you get covered Part D drugs from a non-plan pharmacy, you pay the same as at a plan pharmacy and you can get up to a 30-day supply. Generally, we cover drugs filled at a non-plan pharmacy only when you can't use a network pharmacy, like during a disaster. See the **Evidence of Coverage** for details.

## Who can enroll

You can sign up for this plan if:

- Must be enrolled in Kaiser Permanente through your group plan and meet your group's eligibility requirements.
- You have both Medicare Part A and Part B. (To get and keep Medicare, most people must pay Medicare premiums directly to Medicare.)
- You're a citizen or lawfully present in the United States.
- You don't have end-stage renal disease (ESRD) unless you got ESRD when you were already a member of one of our plans or you were a member of a different plan that was ended.
- You live in the service area for this plan, which includes all of **Honolulu County**. Also, our service area includes these parts of the following counties:
  - **Maui County, in the following ZIP codes only**: 96708, 96713, 96732, 96733, 96753, 96761, 96767, 96768, 96779, 96784, 96788, 96790, and 96793.
  - **Hawaii County, in the following ZIP codes only**: 96704, 96710, 96719, 96720, 96721, 96725, 96726, 96727, 96728, 96737, 96738, 96739, 96740, 96743, 96745, 96749, 96750, 96755, 96760, 96764, 96771, 96773, 96774, 96776, 96778, 96780, 96781, 96783, and 96785.

## Coverage rules

We cover the services and items listed in this document and the Evidence of Coverage, if:

- The services or items are medically necessary.
- The services and items are considered reasonable and necessary according to Original Medicare's standards.
- You get all covered services and items from plan providers listed in our Provider Directory and Pharmacy Directory. But there are exceptions to this rule. We also cover:
  - Care from plan providers in another Kaiser Permanente Region
  - Emergency care
  - Out-of-area dialysis care
  - Out-of-area urgent care (covered inside the service area from plan providers and in rare situations from non-plan providers)
  - Referrals to non-plan providers if you got approval in advance (prior authorization) from our plan in writing

Note: You pay the same plan copays and coinsurance when you get covered care listed above from non-plan providers.

## Referrals

Your plan provider must make a referral before you can get most services or items. But a referral isn't needed for the following:

- Behavioral health services provided by a plan provider
- Emergency services
- Flu shots and pneumonia vaccinations given by a plan provider
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our service area
- Optometry services provided by a plan provider
- Routine women's health care provided by a plan provider
- Second opinions from another plan provider except for certain specialty care
- Sports medicine services provided by a plan provider
- Urgently needed services from plan providers
- Urgently needed services from non-plan providers when plan providers are temporarily unavailable or inaccessible–for example, when you're temporarily outside of our service area

## Prior authorization

Some services or items are covered only if your plan provider gets approval in advance from our plan (sometimes called prior authorization). These are some services and items that require prior authorization:

- Durable medical equipment
- Nonemergency ambulance services
- Post-stabilization care following emergency care from non-plan providers
- Prosthetic and orthotic devices
- Referrals to non-plan providers if services aren't available from plan providers
- Skilled nursing facility care
- Transplants

For details about coverage rules, including services that aren't covered (exclusions), see the Evidence of Coverage.

## Getting care

At most of our plan facilities, you can usually get all the covered services you need, including specialty care, pharmacy, and lab work. You aren't restricted to a particular plan facility or pharmacy, and we encourage you to use the plan facility or pharmacy that will be most convenient for you.

To find our provider locations, see our **Provider Directory** or **Pharmacy Directory** at **kp.org/directory** or ask us to mail you a copy by calling Member Services at **1-800-805-2739**, 7 days a week, 8 a.m. to 8 p.m. (TTY **711**).

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

## Your personal doctor

Your personal doctor (also called a primary care physician) will give you primary care and will help coordinate your care, including hospital stays, referrals to specialists, and prior authorizations. Most personal doctors are in internal medicine or family practice. You must choose one of our available plan providers to be your personal doctor.

You can change your doctor at any time and for any reason. You can choose or change your doctor by calling Member Services or at **kp.org**.

## Help managing conditions

If you have more than 1 ongoing health condition and need help managing your care, we can help. Our case management programs bring together nurses, social workers, and your personal doctor to help you manage your conditions. The program provides education and teaches self-care skills. If you're interested, please ask your personal doctor for more information.

# Notices

## Appeals and grievances

You can ask us to provide or pay for an item or service you think should be covered. If we say no, you can ask us to reconsider our decision. This is called an appeal. You can ask for a fast decision if you think waiting could put your health at risk. If your doctor agrees, we'll speed up our decision.

If you have a complaint thatss not about coverage, you can file a grievance with us. See the **Evidence of Coverage** for details.

## Kaiser Foundation Health Plan

Kaiser Foundation Health Plan, Inc., Hawaii Region is a nonprofit corporation and a Medicare Advantage plan called Kaiser Permanente Senior Advantage.

## Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and doesn't discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente doesn't exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no-cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no-cost language services to people whose primary language isn't English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at 1-800-805-2739 (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 711 Kapiolani Blvd, Honolulu, HI 96813 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 1-800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

## Privacy

We protect your privacy. See the **Evidence of Coverage** or view our **Notice of Privacy Practices** on **kp.org** to learn more.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal. This contract is renewed annually by the Centers for Medicare & Medicaid Services (CMS). By law, our plan or CMS can choose not to renew our Medicare contract.

The benefit information provided is a brief summary, not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. If you receive Extra Help to pay for Medicare Part D prescription drug coverage, premiums and cost sharing will vary based on the level of Extra Help you receive. Please contact the plan for further details.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare You"** handbook. View it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

# Helpful definitions (glossary)

| | |
|---|---|
| **Benefit period** | The way our plan measures your use of skilled nursing facility services. A benefit period starts the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't gotten any inpatient hospital care or skilled care in an SNF for 60 days in a row. The benefit period isn't tied to a calendar year. There's no limit to how many benefit periods you can have or how long a benefit period can be. |
| **Calendar year** | The year that starts on January 1 and ends on December 31. |
| **Coinsurance** | A percentage you pay of our plan's total charges for certain services or prescription drugs. For example, a 20% coinsurance for a $200 item means you pay $40. |
| **Copay** | The set amount you pay for covered services–for example, a $20 copay for an office visit. |
| **Evidence of coverage** | A document that explains in detail your plan benefits and how your plan works. |
| **Maximum out-of-pocket responsibility** | The most you'll pay in copays or coinsurance each calendar year for services that are subject to the maximum. If you reach the maximum, you won't have to pay any more copays or coinsurance for services subject to the maximum for the rest of the year. |
| **Medically necessary** | Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. |
| **Non-plan provider** | A provider or facility that doesn't have an agreement with Kaiser Permanente to deliver care to our members. |
| **Plan** | Kaiser Permanente Senior Advantage |
| **Plan provider** | A plan or network provider can be a facility, like a hospital or pharmacy, or a health care professional, like a doctor or nurse. |
| **Region** | A Kaiser Foundation Health Plan organization. We have Kaiser Permanente Regions located in Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C. |
| **Retail plan pharmacy** | A plan pharmacy where you can get prescriptions. These pharmacies are usually located at plan medical offices. |
| **Service area** | The geographic area where we offer Senior Advantage plans. To enroll and remain a member of our plan, you must live in one of our Senior Advantage plan's service area. |

## Multi-language Interpreter Services

**English**
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-805-2739** (TTY: **711**).

**Spanish**
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-805-2739** (TTY: **711**).

**Chinese**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-805-2739**（TTY：**711**）。

**Vietnamese**
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-805-2739** (TTY: **711**).

**Tagalog**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-805-2739** (TTY: **711**).

**Korean**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

**1-800-805-2739** (TTY: **711**)번으로 전화해 주십시오.

**Japanese**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
**1-800-805-2739**（TTY:**711**）まで、お電話にてご連絡ください。

**Lao**
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-805-2739** (TTY: **711**).

**Ilocano**
PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti **1-800-805-2739** (TTY: **711**).

**Samoan**
MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-800-805-2739** (TTY: **711**).

**Marshallese**
LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk **1-800-805-2739** (TTY: **711**)

**Trukese**
MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori **1-800-805-2739** (TTY: **711**).

**Hawaiian**
E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo hoʻokomo ʻōlelo, loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā **1-800-805-2739** (TTY: **711**).

**Pohnpeian**
Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie Lokaiahn Pohnpei komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call **1-800-805-2739** (TTY: **711**).

**Bisayan**
ATENSYON:  Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad.  Tawag sa **1-800-805-2739** (TTY: **711**).

**Tongan**

FAKATOKANGA'I:  Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia.  Telefoni mai **1-800-805-2739 (TTY: 711**).

| | Benefits | You pay |
|---|---|---|
| **Drug rider 3/15/50/200** | **For each prescription, when the quantity does not exceed:**<br>• a 30-consecutive-day supply of a prescribed drug, or<br>• an amount as determined by the formulary.<br><br>**Self-administered drugs** are covered only when all of the following criteria are met:<br>• prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate,<br>• on the Health Plan Formulary. Senior Advantage members with Medicare Part D are entitled to drugs on the Health Plan Formulary and Kaiser Permanente Hawaii Medicare Drug Formulary. Drugs must be used in accordance with formulary guidelines or restrictions,<br>• the drug is one for which a prescription is required by law,<br>• obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc., or pharmacies we designate, and<br>• drug does not require administration by nor observation by medical personnel. | $3 per prescription for generic Maintenance drugs, $15 per prescription for all other generic drugs, $50 for brand-name drugs, $200 for specialty drugs |
| | **Insulin** | $3 per prescription for generic Maintenance drugs, $15 per prescription for all other generic drugs, $50 for brand-name drugs, $200 for specialty drugs |

**Exclusions:**

- Drugs for which a prescription is not required by law (e.g. over-the-counter drugs) including condoms, contraceptive foams and creams or other non-prescription substances used individually or in conjunction with any other prescribed drug or device. This exclusion does not apply to tobacco cessation drugs and products as described in the prescribed drug section.
- Drugs and their associated dosage strengths and forms in the same therapeutic category as a non-prescription drug that have the same indication as the non-prescription drug.
- Drugs obtained from a non-Kaiser Permanente pharmacy.
- Non-prescription vitamins.
- Drugs when used primarily for cosmetic purposes.
- Medical supplies such as dressings and antiseptics.
- Reusable devices such as blood glucose monitors and lancet cartridges.
- Diabetes supplies such as blood glucose test strips, lancets, syringes and needles.
- Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate.
- Brand-name drugs requested by a Member when there is a generic equivalent.
- Prescribed drugs that are necessary for or associated with excluded or non-covered services, except for Senior Advantage Members with Medicare Part D.
- Drugs related to sexual dysfunction.
- Drugs to shorten the duration of the common cold.
- Drugs related to enhancing athletic performance (such as weight training and body building).
- Any packaging other than the dispensing pharmacy's standard packaging.
- Immunizations, including travel immunizations.
- Contraceptive drugs and devices (to prevent unwanted pregnancies).
- Abortion drugs (such as RU-486).
- Replacement of lost, stolen or damaged drugs.

## Questions and answers about the drug rider

1. ***How does the drug rider work?***
   When you visit a Kaiser Permanente physician, a licensed prescriber or a prescriber we designate, and they prescribe a drug for which a prescription is required by law, you can take the prescription to any Kaiser Permanente pharmacy or pharmacy we designate.

   - In most cases $3 for generic Maintenance drugs, $15 each other generic drugs, $50 for brand drugs, and $200 for specialty drugs when it does not exceed a 30-consecutive-day supply of a prescribed drug (or an amount as determined by the formulary). Each refill of the same prescription will also be provided at the same charge.
   - If you go to a non-Kaiser Permanente pharmacy, you will be responsible for 100% of charges.

2. ***Where are Kaiser Permanente pharmacies located?***
   Most Kaiser Permanente Clinics have a pharmacy on premises. Please consult the Member Handbook for the pharmacy nearest you and its hours of operation.

3. ***Can I get any drug prescribed by my Physician?***
   Our drug formulary is considered a closed formulary, which means that medications on the list are usually covered under the prescription drug rider. However drugs on our formulary may not be automatically covered under your prescription drug rider depending on which plan you.ve selected. Even though nonformulary drugs are generally not covered under your prescription drug rider, your Kaiser Permanente physician can sometimes request a nonformulary drug for you, specifically when formulary alternatives have failed or use of nonformulary drug is medically necessary, provided – the drug is not excluded under the prescription drug rider.

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

4. ***Do I need to present any identification when I receive drugs?***
   Yes, always present your Kaiser Permanente membership ID card, which has your medical record number, to the pharmacist. If you do not have a medical record number, please call the Member Services at 1-800-966-5955.

5. ***What if I need more than a month's supply of medication?***
   Your Kaiser Permanente membership contract entitles you to a maximum one-month's supply per prescription. However, as a convenience to you, our Kaiser Permanente Pharmacies will dispense up to a three-month's supply of certain prescriptions upon request (you will be responsible for three copayment amounts). Dispensing a three-month's supply is done in good faith, presuming you will remain a Kaiser Permanente member for the next three months. If you terminate your membership with Kaiser Permanente before the end of the three-month period, we will bill you the retail price for your remaining drugs. For example, if you end your membership after two months, we will bill you for the remaining one-month's supply. Unless otherwise directed by Kaiser Permanente, refills may be allowed when 75% of the current prescription supply is taken/administered according to prescriber's directions.

6. ***How do I receive prescriptions by mail?***
   Save time and money on refills! If you have prescription drug coverage, you can get a 90-day supply of qualified

prescription drugs covered under your drug rider for the price of 60 by using our convenient mail order service*. And we pay the postage!

You can order your refills at your convenience, 24/7, using one of the methods below.

- For the quickest turnaround time, order online at kp.org.
- Order via our automated prescription refill service by calling (808) 643-7979, press 1.
- Order using our mail-order envelope, available at all Kaiser Permanente clinic locations.
- Order via our Pharmacy Refill Center at (808) 643-7979, press 3 then press 5, Monday to Friday, 8:30 a.m. to 5 p.m. TTY users may call 1-877-447-5990.

So the next time you've used two-thirds of your existing supply of prescription medications, try using one of these convenient options.

If you must pick up your prescriptions at a clinic pharmacy, refillable prescriptions are usually ready for pickup at the designated pharmacy in one business day. Prescriptions requiring a physician's approval are usually ready in two business days. Call the pharmacy or Kaiser Permanente Hawaii's automated prescription refill line in advance to make sure that your prescription is ready. Orders not picked up within one week are returned to stock.

* We are not licensed to mail medications out of state. 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 & Therapeutic Committee.

7. ***What are the definitions of the different classes of drugs?***

- **Generic drugs** are drugs approved by the U.S. Food and Drug Administration (FDA), have the same active ingredient of the Brand-name drugs, are produced and sold under their Generic names after the patent of the Brand-name drug expires, and are on the Health Plan formulary.
- **Maintenance drugs** are those which are used to treat chronic conditions, such as asthma, hypertension, diabetes, hyperlipidemia, cardiovascular disease, and mental health, and are on the Health Plan formulary.
- **Generic Maintenance drugs** are specific Generic drugs used for the treatment of chronic conditions and are on Health Plan's approved list. However, not all Generic drugs used for the treatment of chronic conditions are considered Generic Maintenance drugs.
- **Brand-name drugs** are drugs approved by the U.S. Food and Drug Administration (FDA), produced and sold under the original manufacturer's Brand-name, and are on the Health Plan formulary. Brand-name drugs include single source drugs (where there is only one approved product available for that active ingredient, dosage form, route of administration, and strength).
- **Specialty drugs** are very high-cost drugs approved by the U.S. Food and Drug Administration (FDA) that are on the Health Plan formulary.

| | Benefits | You pay |
|---|---|---|
| **Hearing Aids rider - 60%** | Up to two medically necessary and appropriate **hearing aids**, one for each hearing impaired ear, once every 36 months when prescribed by a KP physician or KP audiologist, and obtained from sources designated by Health Plan<br><br>**Limitations:**<br>• Coverage is limited to the lowest priced model hearing aid in accordance with Kaiser's guidelines that adequately meets the medical needs of the Member.<br>• Hearing aids above the lowest priced model will be provided upon payment of the applicable charges that the Member would have paid for a lowest priced model hearing aid plus all additional charges for any amount above the lowest priced model hearing aid.<br><br>**Exclusions:**<br>• All other hearing aid related costs, including but not limited to: consultation, fitting, rechecks and adjustments for the hearing aid(s). | 60% of applicable charges per ear, once every three years |

**This brochure is only a summary.**

It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, benefit schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control.

| | Benefits | You pay |
|---|---|---|
| **Alternative medicine rider D - 12 visits / $20** | **Chiropractic, acupuncture and massage therapy services**<br>**Up to a combined maximum of 12 office visits per calendar year.**<br>**This rider does not cover services which are performed or prescribed by a Kaiser Permanente physician or other Kaiser Permanente health care provider.**<br>Services must be performed and received from Participating Chiropractors, Participating Acupuncturists, and Participating Massage Therapists of **American Specialty Health Networks (ASHN)**. Covered Services include:<br>• **Chiropractic services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders which are authorized by ASHN and performed by a Participating Chiropractor.<br>• **Acupuncture services** for the treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea or Pain Syndromes which are authorized by ASHN and performed by a Participating Acupuncturist.<br>• **Massage therapy services** for the treatment and diagnosis of myofascial/musculoskeletal pain syndromes which are referred by a Participating Chiropractor or Kaiser Permanente Physician, authorized by ASHN and performed by a Participating Massage Therapist.<br>• **Adjunctive therapy** as set forth in a treatment plan approved by ASHN, may involve chiropractic modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation; acupuncture therapies such as acupressure, moxibustion, and cupping; and other therapies.<br>• **Diagnostic tests** are limited to those required for further evaluation of the Member's condition and listed on the payor summary and fee schedule. Medically necessary x-rays, radiologic consultations, and clinical laboratory studies must be performed by either an appropriately certified Chiropractor or staff member or referred to a facility that has been credentialed to meet the criteria of ASHN. Diagnostic tests must be performed or ordered by a Participating Chiropractor and authorized by ASHN. | $20 copayment per office visit |

| Benefits | You pay |
|---|---|
| **Chiropractic appliances** when prescribed and provided by a Participating Chiropractor and authorized by ASHN. | Payable up to a maximum of $50 per calendar year |

**Exclusions:**

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

- Services or treatment for pre-employment physicals or vocational rehabilitation.
- Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances (except as covered above in this brochure) or durable medical equipment.
- Services provided by a chiropractor, acupuncturist or massage therapist outside the State of Hawaii.
- All auxiliary aids and services, such as interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
- Adjunctive therapy not associated with acupuncture or chiropractic services.
- Services and/or treatment which are not documented as Medically Necessary services.
- Any services or treatment not authorized by ASHN, except for an initial examination.
- Any office visits beyond 12 per calendar year.

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

1. **Do I need to see my Kaiser Permanente physician to obtain a referral for a Participating Chiropractor or Participating Acupuncturist?**
   No. These alternative medicine services do not require a Kaiser Permanente physician's approval.

2. **When are massage therapy services covered under this Rider?**
   Massage Therapy Services for muscular and soft tissue disorders are referred by a Participating Chiropractor or Kaiser Permanente Physician, authorized by ASHN and performed by a Participating Massage Therapist.

3. **How do I choose a chiropractor, acupuncturist or massage therapist?**
   You may select any chiropractor, acupuncturist or massage therapist who participates with ASHN. You may obtain a list with their addresses and phone numbers by calling the Kaiser Permanente Customer Service Center at 432-5955 on Oahu, and 1-800-966-5955 on Neighbor Islands. You may also view the list by logging on to our website at www.kp.org.

4. **How do I obtain chiropractic or acupuncture services in Hawaii?**
   Simply select a Participating Chiropractor or Participating Acupuncturist and call to set-up an appointment. At your appointment, present your Kaiser Permanente membership ID card and pay your designated copayment.

5. **Will an X-ray be covered if it is ordered by my chiropractor and performed at a Kaiser Permanente location?**
   Only medically necessary X-rays authorized by ASHN are covered. The X-rays must be performed in either a Participating Chiropractor's office or an ASHN ancillary provider's office in order to be covered.

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**kp.org/medicare**

Kaiser Foundation Health Plan, Inc.
711 Kapiolani Blvd.
Honolulu, HI 96813

Have questions?
Please call Member Services at **1-800-805-2739** (TTY **711**) toll free
Seven days a week, 8 a.m. to 8 p.m.

**Please recycle.**

KAISER PERMANENTE®