

# Kaiser Foundation Health Plan, Inc. Hawaii Region

[my.kaiserpermanente.org/federalemplee](http://my.kaiserpermanente.org/federalemplee)

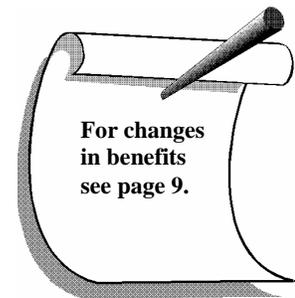


## 2005

### A Health Maintenance Organization

**Serving:** *Islands of Maui, Oahu, and Hawaii  
(except for zip codes 96718, 96772, and 96777)*

**Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 8 for requirements.**



*This Plan has excellent accreditation from the NCQA. See the 2005 Guide for more information on accreditation.*

**Enrollment code for this Plan:**

- 631 High Option Self Only**
- 632 High Option Self and Family**
- 634 Standard Option Self Only**
- 635 Standard Option Self and Family**

**Special Notice:** The Plan has eliminated a portion of its service area for 2005. If you are enrolled in this Plan and live on the island of Kauai, you must select another health plan for 2005 during Open Season. Enrollees who do not choose a new health plan will have to travel to the Plan's remaining service area to receive full benefits.

Authorized for distribution by the:



**United States  
Office of Personnel Management**  
Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>

**RI 73-005**



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at [www.healthierfeds.opm.gov](http://www.healthierfeds.opm.gov) for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, [www.hhs.gov/safety/index.html](http://www.hhs.gov/safety/index.html), which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM website at [www.opm.gov/insure](http://www.opm.gov/insure). I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

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

Kay Coles James

Director



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

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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.

- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at [www.opm.gov/insure](http://www.opm.gov/insure) on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

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

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

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

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

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# Table of Contents

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Introduction .....	3
Plain Language .....	3
Stop Health Care Fraud! .....	3
Preventing medical mistakes .....	5
Section 1. Facts about this HMO plan .....	7
How we pay providers .....	7
Your Rights .....	7
Service Area .....	7
Section 2. How we change for 2005 .....	9
Program-wide changes .....	9
Changes to this Plan .....	9
Section 3. How you get care .....	10
Identification cards .....	10
Where you get covered care .....	10
• Plan providers .....	10
• Plan facilities .....	10
What you must do to get covered care .....	11
• Primary care .....	11
• Specialty care .....	11
• Hospital care .....	12
Circumstances beyond our control .....	12
Services requiring our prior approval .....	12
Section 4. Your costs for covered services .....	14
Copayments .....	14
Deductible .....	14
Coinsurance .....	14
Fees when you fail to make your copayment or coinsurance .....	14
Fees when you miss a medical appointment .....	14
Your catastrophic protection out-of-pocket maximum .....	14
Section 5. Benefits – OVERVIEW (See page 9 for how our benefits changed this year and pages 77 and 78 for benefit summaries.) .....	15
Section 5(a) Medical services and supplies provided by physicians and other health care professionals .....	17
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals .....	31
Section 5(c) Services provided by a hospital or other facility, and ambulance services .....	37
Section 5(d) Emergency services/accidents .....	42
Section 5(e) Mental health and substance abuse benefits .....	45
Section 5(f) Prescription drug benefits .....	48
Section 5(g) Special features .....	51
• Services from other Kaiser Permanente Plans .....	51
• Interpretive services .....	51
• 24 hour advice line .....	51
• Travel benefit .....	52
• Flexible benefits option .....	53
• Travel assistance .....	53
Section 5(h) Dental benefits .....	54

Section 6. General exclusions – things we don’t cover .....	56
Section 7. Filing a claim for covered services .....	57
Section 8. The disputed claims process .....	58
Section 9. Coordinating benefits with other coverage .....	60
When you have other health coverage .....	60
What is Medicare? .....	60
• Should I enroll in Medicare? .....	61
• If you enroll in Medicare Part B .....	61
• The Original Medicare Plan (Part A or Part B) .....	61
• Medicare Advantage .....	63
TRICARE and CHAMPVA .....	65
Workers’ Compensation .....	65
Medicaid .....	65
When other Government agencies are responsible for your care .....	65
When others are responsible for injuries .....	65
Section 10. Definitions of terms we use in this brochure .....	66
Section 11. FEHB Facts .....	68
Coverage information .....	68
• No pre-existing condition limitation .....	68
• Where you can get information about enrolling in the FEHB Program .....	68
• Types of coverage available for you and your family .....	68
• Children’s Equity Act .....	69
• When benefits and premiums start .....	69
• When you retire .....	69
When you lose benefits .....	69
• When FEHB coverage ends .....	69
• Spouse equity coverage .....	70
• Temporary Continuation of Coverage (TCC) .....	70
• Converting to individual coverage .....	70
• Getting a Certificate of Group Health Plan Coverage .....	71
Section 12. Two Federal Programs complement FEHB benefits .....	72
The Federal Flexible Spending Account Program – <i>FSAFEDS</i> .....	72
The Federal Long Term Care Insurance Program .....	75
Index .....	76
Summary of benefits for Kaiser Foundation Health Plan, Inc. – Hawaii Region .....	77
2005 Rate Information for Kaiser Foundation Health Plan, Inc. – Hawaii Region .....	79

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## Introduction

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

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 9. Rates are shown on the back cover of this brochure.

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## Plain Language

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All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means “we” or “Plan” means Kaiser Foundation Health Plan, Inc., Hawaii Region.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 808/432-5955 and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE  
202-418-3300**

**OR WRITE TO:**  
**United States Office of Personnel Management  
 Office of the Inspector General Fraud Hotline  
 1900 E Street NW Room 6400  
 Washington, DC 20415-1100**

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

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## Preventing medical mistakes

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

1. **Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

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

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery?
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

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

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## Section 1. Facts about this HMO plan

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This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services or services covered under our travel benefit, from non-Plan providers, you may have to submit claim forms.

**You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.**

### How we pay providers

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

### Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website ([www.opm.gov/insure](http://www.opm.gov/insure)) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Non-profit group practice health maintenance organization
- This Plan is part of the Kaiser Permanente Medical Care Program, a group of non-profit organizations and contracting medical groups that serve over 8 million members nationwide
- 47 years in existence
- Our three entities – Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and Hawaii Permanente Medical Group, Inc. (HPMG, a for-profit Hawaii corporation) – work together to provide you with a full range of medical care, benefits, and services
- We credential Plan providers according to national standards
- Our Moanalua Medical Center is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

If you want more information about us, call the Plan's Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Maui or Hawaii, or 877/447-5990 TTY, or write to the Health Plan office at 711 Kapiolani Blvd., Honolulu, Hawaii 96813. You may also contact us by fax at 808/432-5300 or visit our website at [my.kaiserpermanente.org/federalemplee](http://my.kaiserpermanente.org/federalemplee).

### Service Area

2005 Kaiser Foundation Health Plan, Inc.  
Hawaii Region

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

The Islands of Oahu and Maui

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

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente service area, you can receive virtually all of the benefits of this Plan at any other Kaiser Permanente facility. You must pay the charges or copayments imposed by the Kaiser Permanente Plan you are visiting. See Section 5(g), Special Features, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described on page 52; and for emergency care obtained from any non-Plan provider, as described on page 42. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

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## Section 2. How we change for 2005

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Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

### Program-wide changes

- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

### Changes to this Plan

#### Both High Option and Standard Option:

- Your share of the non-Postal premium will increase by 6.0% for Self Only or increase 6.0% for Self and Family under the High Option and will increase by 2.3% for Self Only or 2.3% for Self and Family under the Standard Option.
- Kauai is no longer part of our service area.
- Your copayments and coinsurance for breast prostheses following a mastectomy and internal prosthetic devices do not count toward your out-of-pocket maximum.
- We increased the charge for externally worn breast prostheses and surgical bras, and for internal prosthetic devices to 50% of our allowance.
- We increased the fee for the Bariatric Surgery Program class to \$1,000.
- We increased the charge for certain FDA approved contraceptives to 50% of charges for oral contraceptives; diaphragms or cervical caps; and injectable contraceptives, IUDs, or implanted time-release contraceptives. There is no maximum on your payments for contraceptives.

#### High Option:

- We increased the office visit copayment to \$12.
- We increased the charge for outpatient lab, x-ray and other diagnostic tests, as well as for endoscopy and biopsy procedures, to 10% of our allowance.

#### Standard Option:

- We increased the office visit copayment to \$20.
- We eliminated the charge for preventive screenings. You pay nothing.

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## Section 3. How you get care

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### Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 10 days after the effective date of your enrollment, or if you need replacement cards, call us at 808/432-5955 on Oahu, or at 800/966-5955 on Maui or Hawaii, or write to us at: Kaiser Permanente Customer Service Center, 711 Kapiolani Boulevard, Honolulu, Hawaii 96813. You may also request replacement cards through our website at [my.kaiserpermanente.org/federalemmployees](http://my.kaiserpermanente.org/federalemmployees).

### Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and coinsurance. You will not have to file claims, except for emergency, urgent care services outside our service area and for covered services while you travel.

#### • Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We contract with the Hawaii Permanente Medical Group, an independent multi-specialty group of physicians ("Plan physicians"), to provide or arrange all necessary physician care for you. These physicians are members of American Specialty Boards or are Board eligible. Your medical care is provided through physicians, nurse practitioners, physician assistants, and other skilled medical personnel working as medical teams at our facilities. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. Services such as physical therapy, laboratory, and X-ray services are available to you at our facilities. Plan physicians can also arrange any necessary specialty care for you. Hospital care is provided to you through the Kaiser Permanente Moanalua Medical Center on Oahu and several local community hospitals on Maui or Hawaii. Dental services are provided by Hawaii Dental Service.

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

#### • Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We offer comprehensive health care at 17 Plan facilities conveniently located on the Islands of Oahu, Maui and Hawaii; and through specialists, hospitals and other providers in the community following an authorized referral.

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

You must receive your health care services at Plan facilities, except if you have an emergency. If you are visiting another Kaiser Permanente service area, you may receive health care services from those Kaiser Permanente facilities. Your travel benefit allows you to receive follow-up or continuing care while you travel anywhere.

## **What you must do to get covered care**

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

Choose your primary care physician from this Plan's provider directory. It lists Plan facilities and services available at each facility with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Maui or Hawaii.

### **• Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

### **• Specialty care**

Your primary care physician will refer you to a specialist for needed care and will obtain the necessary authorization. The referral will describe the services you will receive. If you need further services, you must return to the primary care physician after you receive the services described in the referral. The primary care physician must provide or authorize all follow-up care. If your specialist recommends additional visits or services, your primary care physician will review the recommendation and authorize the visits or services, as appropriate. Do not go to the specialist for return visits unless your primary care physician and Plan gives you a referral. A woman may see her gynecologist without a referral. You may also receive vision care and mental health and substance abuse services without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will arrange for you to see your specialist. Your specialist will develop a treatment plan for a certain number of visits without additional referrals.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
  - Reduce our service area and you enroll in another FEHB plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Center immediately at 808/432-5955 on Oahu, or at 800/966-5955 on Maui or Hawaii. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

**Circumstances beyond our control**

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

**Services requiring our prior approval**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior authorization. Your physician must obtain approval for services which include, but are not limited to: prostheses, durable medical equipment, transplants, in vitro fertilization, hospice, referrals to facilities outside of Hawaii, air ambulance to facilities outside of Hawaii, and care delivered by a non-Plan physician.

Requests for these services are made to your primary care physician just like any other referral. Your primary care physician submits the request, with supporting documentation. If your request is not approved, you have a right to appeal by submitting it in writing by mailing or delivering it to Kaiser Foundation Health Plan, Inc., Attn: Affiliated Care/Appeals, 501 Alakawa St., Honolulu, HI 96817, or by fax to 808/432-7518. If you want additional services, you must make the request to your primary care physician.

Emergency services do not require prior authorization. However, if you are admitted to a non-Kaiser Permanente facility, you or your family member must notify the Plan within 48 hours, or as soon as is reasonably possible or your claim may be denied.

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## Section 4. Your costs for covered services

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You must share the costs of some services. You are responsible for:

### **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician, you pay a copayment of \$12 (High Option) or \$20 (Standard Option) per office visit.

### **Deductible**

We do not have a deductible.

### **Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for certain services you receive. Example: In our Plan, you pay 20% of our allowance for in vitro fertilization.

### **Fees when you fail to make your copayment or coinsurance**

If you do not pay your copayment or coinsurance at the time you receive services, we will bill you. You will be required to pay a \$20 charge for each bill sent for unpaid services.

### **Fees when you miss a medical appointment**

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

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

### **Your catastrophic protection out-of-pocket maximum**

After your copayments and coinsurance total \$1,500 per person or \$4,500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Drugs and contraceptive devices
- Diabetes equipment and supplies to operate the equipment
- Breast prostheses following a mastectomy
- Internal prosthetic devices
- Dental services
- Blood
- Chiropractic and alternative treatments
- \$25 charges paid for follow-up or continuing care outside the service area
- Any non-FEHB benefits

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

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## Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and pages 77 and 78 for benefit summaries.)

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NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 808/432-5955 on Oahu, or at 800/966-5955 on Maui or Hawaii or at our website at [my.kaiserpermanente.org/federalemployees](http://my.kaiserpermanente.org/federalemployees).

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	17
Diagnostic and treatment services.....	17
Lab, X-ray and other diagnostic tests.....	18
Preventive care, adult.....	18
Preventive care, children.....	20
Maternity care.....	21
Family planning.....	22
Infertility services.....	23
Allergy care.....	23
Treatment therapies.....	24
Physical and occupational therapies.....	24
Speech therapy.....	25
Hearing services (testing, treatment, and supplies).....	25
Vision services (testing, treatment, and supplies).....	25
Foot care.....	26
Orthopedic and prosthetic devices.....	26
Durable medical equipment (DME).....	27
Home health services.....	27
Chiropractic.....	28
Alternative treatments.....	28
Educational classes and programs.....	29
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	31
Surgical procedures.....	31
Reconstructive surgery.....	33
Oral and maxillofacial surgery.....	34
Organ/tissue transplants.....	35
Anesthesia.....	36
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	37
Inpatient hospital.....	37
Outpatient hospital or ambulatory surgical center.....	39
Skilled nursing care benefits.....	40
Hospice care.....	41
Ambulance.....	41
Section 5(d) Emergency services/accidents.....	42
Emergency within our service area.....	43
Emergency outside our service area.....	43
Ambulance.....	44
Section 5(e) Mental health and substance abuse benefits.....	45
Mental health and substance abuse benefits.....	45
Section 5(f) Prescription drug benefits.....	48
Covered medications and supplies.....	49

Section 5(g) Special features ..... 51

- Services from other Kaiser Permanente Plans ..... 51
- Interpretive services ..... 51
- 24 hour advice line ..... 51
- Travel benefit ..... 52
- Flexible benefits option ..... 53
- Travel assistance ..... 53

Section 5(h) Dental benefits ..... 54

- Accidental injury benefit ..... 54
- Dental benefit ..... 54

Summary of benefits for Kaiser Foundation Health Plan, Inc. – Hawaii Region - 2005 ..... 77

2005 Rate Information for Kaiser Foundation Health Plan, Inc. – Hawaii Region ..... 79

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

**Here are some important things you should keep in mind about these benefits:**

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: You pay only \$5 under our High Option and \$12 under our Standard Option if you enroll in our Medicare Advantage Plan and assign your Medicare benefits to the Plan.

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Benefit Description		
<b>Diagnostic and treatment services</b>	<b>You pay – High Option</b>	<b>You pay – Standard Option</b>
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> <li>• In a medical office</li> <li>• Initial examination of a newborn child covered under a family enrollment</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> <li>• In an urgent care center</li> </ul>	\$12 per office visit	\$20 per office visit
<ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• In a skilled nursing facility (up to 100 days per benefit period)</li> </ul>	Nothing	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>House calls by physicians</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Lab, X-ray and other diagnostic tests	You pay – High Option	You pay – Standard Option
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	10% of our allowance	50% of our allowance
Preventive care, adult		
Preventive screenings: <ul style="list-style-type: none"> <li>• Total blood cholesterol</li> <li>• Blood pressure check</li> <li>• Chlamydia detection</li> <li>• Fecal occult blood test</li> <li>• Gonorrhea culture</li> <li>• HIV screening</li> <li>• Osteoporosis screening</li> </ul> <p>Note: You should consult with your physician to determine what is appropriate for you.</p>	Nothing after the \$12 office visit	Nothing after the \$20 office visit

*Preventive care, adult—continued on next page*

<b>Preventive care, adult</b> <i>(continued)</i>	<b>You pay – High Option</b>	<b>You pay – Standard Option</b>
Routine screenings, such as: <ul style="list-style-type: none"> <li>• Colorectal cancer screening, including               <ul style="list-style-type: none"> <li>– Sigmoidoscopy screening – every five years starting at age 50</li> </ul> </li> </ul>	Nothing after the \$12 office visit	Nothing after the \$20 office visit
<ul style="list-style-type: none"> <li>– Double contrast barium enema – every five years starting at age 50</li> </ul>	10% of our allowance	50% of our allowance
<ul style="list-style-type: none"> <li>– Colonoscopy screening – every ten years starting at age 50</li> </ul> Notes: <ul style="list-style-type: none"> <li>• You should consult with your physician to determine what is appropriate for you.</li> <li>• We cover fecal occult blood test under preventive screenings</li> </ul>	Nothing after the \$12 office visit	Nothing after the \$20 office visit
<ul style="list-style-type: none"> <li>• Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</li> </ul> Note: You should consult with your physician to determine what is appropriate for you.	10% of our allowance	50% of our allowance
<ul style="list-style-type: none"> <li>• Routine Pap smear test</li> </ul>	Nothing after the \$12 office visit	Nothing after the \$20 office visit
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> </ul> Note: You should consult with your physician to determine what is appropriate for you.	Nothing after the \$12 office visit	Nothing after the \$20 office visit

*Preventive care, adult—continued on next page*

Preventive care, adult <i>(continued)</i>	You pay – High Option	You pay – Standard Option
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccines, annually</li> <li>• Pneumococcal vaccines, age 65 and over</li> </ul>	Nothing	Nothing
Injectable travel immunizations  Notes: <ul style="list-style-type: none"> <li>• You will also pay the office visit copayment when you receive your immunization.</li> <li>• We cover oral travel immunizations under the prescription drug benefit.</li> </ul>	50% of our allowance	50% of our allowance
<i>Not covered:</i>  <i>Physical exams and related reports and paperwork required for:</i> <ul style="list-style-type: none"> <li>• <i>Obtaining or continuing employment</i></li> <li>• <i>Insurance</i></li> <li>• <i>Sports, camps</i></li> <li>• <i>Attending schools</i></li> <li>• <i>Travel</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Preventive care, children</b>		
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	Nothing	Nothing
<ul style="list-style-type: none"> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>– Eye exams through age 17 to determine the need for vision correction</li> <li>– Ear exams through age 17 to determine the need for hearing correction</li> <li>– Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> <li>• Well-child care for routine examinations up to age 22</li> </ul>	\$12 per office visit	\$20 per office visit

*Preventive care, children—continued on next page*

Preventive care, children <i>(continued)</i>	You pay – High Option	You pay – Standard Option
Injectable travel immunizations  Notes: <ul style="list-style-type: none"> <li>• You will also pay the office visit copayment when you receive your immunization.</li> <li>• We cover oral travel immunizations under the prescription drug benefit.</li> </ul>	50% of our allowance	50% of our allowance
<i>Not covered:</i>  <i>Physical exams and related reports and paperwork required for:</i> <ul style="list-style-type: none"> <li>• <i>Obtaining or continuing employment</i></li> <li>• <i>Insurance</i></li> <li>• <i>Sports, camps</i></li> <li>• <i>Attending schools</i></li> <li>• <i>Travel</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Maternity care		
After confirmation of pregnancy, routine maternity (obstetrical) care as determined by a Plan physician, such as: <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postpartum care</li> </ul> Note: Here are some things to keep in mind: <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.</li> </ul>	Nothing	Nothing

*Maternity care—continued on next page*

Maternity care <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<p>Note: Here are some things to keep in mind: <i>(continued)</i></p> <ul style="list-style-type: none"> <li>• See Section 5(c), Inpatient hospital for copayments related to room and board for maternity and newborn children</li> <li>• We cover hospitalization and surgical services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgical benefits.</li> <li>• We cover non-routine maternity care the same as for illness and injury. See Section 5(a) for medical services and supplies provided by physicians and other health care professionals, Section 5(b) for surgical and anesthesia services provided by physicians and other health care professionals, Section 5(c) for services provided by a hospital or other facility and ambulance services, and Section 5(d) for emergency services.</li> </ul>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Routine sonograms to determine fetal age, size, or sex</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Family planning		
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Family planning services, including counseling</li> <li>• Voluntary sterilization (See Surgical procedures Section 5(b))</li> <li>• Insertion of surgically implanted time-release contraceptive drugs</li> <li>• Injection of contraceptive drugs</li> <li>• Insertion of intrauterine devices (IUDs)</li> </ul> <p>Note: We cover FDA approved contraceptive drugs and devices under the prescription drug benefit.</p>	\$12 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Genetic counseling</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Infertility services	You pay – High Option	You pay – Standard Option
<p>Diagnosis and treatment of involuntary infertility, such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>– Intravaginal insemination (IVI)</li> <li>– Intracervical insemination (ICI)</li> <li>– Intrauterine insemination (IUI)</li> </ul> </li> </ul>	\$12 per office visit	\$20 per office visit
<p>One in vitro fertilization (IVF) procedure per lifetime (for females who qualify under Hawaii law)</p> <p>Note: We cover drugs used to treat involuntary infertility and in vitro fertilization under the prescription drug benefit, and laboratory tests under the laboratory benefit.</p>	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <p><i>These exclusions apply to fertile as well as infertile individuals or couples:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as embryo transfer, GIFT, and ZIFT</i></li> <li>• <i>Services and supplies related to excluded ART procedures</i></li> <li>• <i>Cost of donor sperm and donor egg and services related to their procurement, processing, and storage</i></li> <li>• <i>Infertility service when either member of the family has been voluntarily sterilized</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Allergy care		
<ul style="list-style-type: none"> <li>• Allergy testing</li> <li>• Allergy treatment and injections</li> </ul>	\$12 per office visit	\$20 per office visit
Allergy serum	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Provocative food testing</i></li> <li>• <i>Sublingual allergy desensitization</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Treatment therapies	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/Tissue Transplants.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: We cover GHT and chemotherapy drugs under the prescription drug benefit.</p>	\$12 per office visit	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Physical and occupational therapies		
<p>Up to two consecutive months of therapy per condition if significant improvement can be expected within that period:</p> <ul style="list-style-type: none"> <li>• Physical therapy by qualified physical therapists and/or assistants to restore bodily function when you have a total or partial loss of bodily function due to illness or injury</li> <li>• Occupational therapy by occupational therapists and/or assistants to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life</li> </ul>	\$12 per outpatient visit Nothing for inpatient	\$20 per outpatient visit Nothing for inpatient
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term physical therapy or occupational therapy</i></li> <li>• <i>Exercise programs</i></li> <li>• <i>Cardiac rehabilitation</i></li> <li>• <i>Occupational therapy supplies</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

<b>Speech therapy</b>	<b>You pay – High Option</b>	<b>You pay – Standard Option</b>
Up to two consecutive months of therapy per condition: <ul style="list-style-type: none"> <li>• Speech therapy by speech therapists when medically necessary</li> </ul>	\$12 per outpatient visit  Nothing for inpatient	\$20 per outpatient visit  Nothing for inpatient
<i>Not covered:</i>  <i>Speech therapy that is not medically necessary such as:</i> <ul style="list-style-type: none"> <li>• Therapy for educational placement or other educational purposes</li> <li>• Training to improve fluency or modify dialect</li> <li>• Voice therapy for occupation or performing arts</li> <li>• Therapy supplies</li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Hearing services (testing, treatment, and supplies)</b>		
<ul style="list-style-type: none"> <li>• Hearing testing for adults to determine the need for hearing correction</li> <li>• Hearing testing for children through age 17</li> </ul>	\$12 per office visit	\$20 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Hearing aids, testing, and examinations for them</li> <li>• All other hearing testing</li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Vision services (testing, treatment, and supplies)</b>		
<ul style="list-style-type: none"> <li>• Diagnosis and treatment of diseases of the eye</li> <li>• Eye exam for children to determine the need for vision correction through age 17 (see page 20, Preventive care, children)</li> <li>• Eye refractions (for a written lens prescription for eyeglasses, but not for contact lenses)</li> </ul>	\$12 per office visit	\$20 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Eyeglasses</li> <li>• Contact lenses</li> <li>• Eye exercises and orthoptics</li> <li>• Radial keratotomy and other refractive surgery such as lasik</li> </ul>	<i>All charges</i>	<i>All charges</i>

Foot care	You pay – High Option	You pay – Standard Option
No benefit, except for diabetes	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices		
<ul style="list-style-type: none"> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• We cover surgery necessary to insert the device.</li> <li>• These items are covered only when preauthorized in writing by the Plan and when obtained through sources designated by the Plan.</li> </ul>	50% of our allowance	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Comfort, convenience, or luxury equipment or features</i></li> <li>• <i>Orthopedic devices and corrective shoes</i></li> <li>• <i>Braces and splints</i></li> <li>• <i>Durable medical equipment</i></li> <li>• <i>External prosthetic devices, except as listed above</i></li> <li>• <i>Prosthetic devices and supplies related to sexual dysfunction</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Take home items</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Durable medical equipment (DME)	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> <li>• Glucose meter (and control solutions)</li> <li>• External insulin pump</li> <li>• Supplies necessary to operate these items</li> </ul> <p>Note: These items are covered only when preauthorized in writing by the Plan and obtained through sources designated by the Plan.</p>	50% of our allowance	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• All other durable medical equipment</li> </ul>	<i>All charges</i>	<i>All charges</i>
Home health services		
<p>Services ordered by a physician to homebound members residing in the service area:</p> <ul style="list-style-type: none"> <li>• Nursing</li> <li>• Medical social services and home health aide when related to physical therapy, speech therapy, or occupational therapy</li> <li>• Medical supplies included in the plan of care</li> </ul> <p>Note: We cover IV therapy and medications under the prescription drug benefit. We cover physical and occupational therapies under the physical and occupational therapies benefit. We cover speech therapy under the speech therapy benefit.</p>	\$12 per visit	\$20 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Nursing care requested by you or your family for you or your family's convenience</li> <li>• Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</li> <li>• Care that your physician determines can be appropriately provided in the medical office, hospital, or skilled nursing facility</li> <li>• Prosthetics, durable medical equipment, supplies, and drugs (not part of home infusion program)</li> <li>• Personal care items</li> <li>• Services outside our service areas</li> </ul>	<i>All charges</i>	<i>All charges</i>

Chiropractic	You pay – High Option	You pay – Standard Option
<p>Up to a maximum of 20 combined chiropractic and acupuncture visits per calendar year:</p> <ul style="list-style-type: none"> <li>• Chiropractic services for the treatment or diagnosis of neuromusculo-skeletal disorders as set forth in a treatment plan approved by the ASHN</li> <li>• Adjunctive therapy as set forth in a treatment plan approved by the ASHN</li> <li>• X-rays</li> </ul> <p>Note: Services must be performed by and received from Participating Chiropractors of American Specialty Health Networks™ (ASHN). Contact Kaiser Permanente Customer Service Center at 808/432-5955 on Oahu, or 800/966-5955 on Maui or Hawaii.</p>	\$12 per office visit	\$20 per office visit
<p>Chiropractic appliances when prescribed by a participating chiropractor and authorized by ASHN.</p> <p>Note: <b>We pay no more than \$50 per calendar year.</b> When the \$50 maximum is reached, you must pay the full retail price for all chiropractic appliances for the remainder of the calendar year.</p>	All charges over \$50	All charges over \$50
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Any services or treatment not authorized by ASHN, except for an initial examination</i></li> <li>• <i>Services related to the chiropractic treatment that is performed or prescribed by a Plan physician</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Alternative treatments		
<p>Up to a maximum of 20 combined chiropractic and acupuncture visits per calendar year:</p> <ul style="list-style-type: none"> <li>• Acupuncture services for the treatment or diagnosis of neuromusculo-skeletal disorders, nausea or pain syndromes as set forth in a treatment plan approved by the ASHN</li> <li>• Adjunctive therapy as set forth in a treatment plan approved by the ASHN</li> </ul> <p>Note: Services must be performed by and received from Participating Acupuncturists of American Specialty Health Networks™ (ASHN). Contact Kaiser Permanente Customer Service Center at 808/432-5955 on Oahu, or 800/966-5955 on Maui or Hawaii.</p>	\$12 per office visit	\$20 per office visit

*Alternative treatments—continued on next page*

Alternative treatments <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Any services or treatment not authorized by ASHN, except for an initial examination</li> <li>• Services related to the acupuncture treatment that is performed or prescribed by a Plan physician</li> <li>• Other alternative treatments such as naturopathic services, hypnotherapy, and biofeedback</li> <li>• Traditional Chinese Herbal Supplements</li> <li>• All other forms of alternative treatment</li> </ul>	All charges	All charges
<b>Educational classes and programs</b>		
<p>Our Health Education Department and Lifestyle Program offers a wide variety of classes to members and the public. Participants can learn how to take charge of their own health and well-being, manage their chronic conditions, give up unhealthy habits, and make positive, health enhancing changes in their lifestyle.</p>		
<p>Patient education classes, such as:</p> <ul style="list-style-type: none"> <li>• Cholesterol Classes</li> <li>• Living and Learning with Diabetes</li> </ul>	\$12 per visit	\$20 per visit
<p>Lifestyle and health promotion classes, such as:</p> <ul style="list-style-type: none"> <li>• 55 Alive Mature Driving</li> <li>• Body Conditioning</li> <li>• Childbirth Preparation/Lamaze Class</li> <li>• Couples Communication I</li> <li>• Healthier Living-Managing on-going health conditions</li> <li>• Heart Saver (Basic CPR-Course A)</li> <li>• Iyengar Yoga</li> <li>• Managing Chronic Pain</li> <li>• Parenting Patterns Workshop</li> <li>• Prenatal/Post-Partum Exercise</li> </ul>	Class fee varies from \$10 to \$93	Class fee varies from \$10 to \$93
<ul style="list-style-type: none"> <li>• Bariatric Surgery Program</li> </ul>	Class fee is \$1,000	Class fee is \$1,000

*Educational classes and programs—continued on next page*

Educational classes and programs <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<p>Other classes (including support groups) such as:</p> <ul style="list-style-type: none"> <li>• Arthritis Support Group</li> <li>• Breastfeeding Your Baby</li> <li>• H.O.P.I.N.G. (Helping Other Parents In Normal Grieving)</li> <li>• Menopausal Years</li> <li>• Mothers Share Group</li> <li>• New Sibling Class/Tour</li> <li>• Stroke Club</li> </ul>	Nothing	Nothing
<p>Smoking Cessation Program</p> <p>Our nicotine dependence/smoking cessation program offers self-help information, group appointments, telephone counseling and support, and monthly sessions. You must complete our smoking cessation class to have your nicotine replacement therapy medications covered under the prescription drug benefit.</p>	\$12 per class	\$20 per class

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

**Here are some important things you should keep in mind about these benefits:**

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

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Benefit Description		
Surgical procedures	You pay – High Option	You pay - Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care</li> <li>• Pre-surgical testing</li> <li>• Correction of amblyopia and strabismus</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see reconstructive surgery)</li> </ul>	<p>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>

*Surgical procedures—continued on next page*

Surgical procedures <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> <li>• Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over</li> </ul> <p>Note: We require completion of the Bariatric Surgery Program class (see Section 5(a)) before this surgery.</p> <ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices</li> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> <li>• Insertion of surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs).</li> </ul> <p>Note: We cover surgically implanted time-release contraceptive drugs and intrauterine devices under the prescription drug benefit.</p> <ul style="list-style-type: none"> <li>• Treatment of burns</li> </ul>	<p>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<ul style="list-style-type: none"> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> </ul>	<p>10% of our allowance</p>	<p>50% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, and which will not result in significant improvement in physical function</i></li> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Reconstructive surgery	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance; and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; webbed fingers and toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance on the other breast;</li> <li>– treatment of any physical complications, such as lymphedemas; and</li> <li>– breast prostheses and surgical bras and replacements (see prosthetic devices).</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, and which will not result in significant improvement in physical function</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Oral and maxillofacial surgery	You pay – High Option	You pay – Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones</li> <li>• Surgical correction of cleft lip, cleft palate, or severe functional malocclusion</li> <li>• Removal of stones from salivary ducts</li> <li>• Excision of leukoplakia or malignancies</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures</li> <li>• Medical and surgical treatment of TMJ (non-dental)</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures</li> </ul>	<p>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Shortening of the mandible or maxillae for cosmetic purposes</i></li> <li>• <i>Correction of malocclusion</i></li> <li>• <i>Any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Organ/tissue transplants	You pay – High Option	You pay – Standard Option
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Simultaneous pancreas-kidney</li> <li>• Liver</li> <li>• Lung: Single –Double</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> </ul> <p>Note: We cover some directly related medical and hospital expenses of the donor when we cover your transplant. However, there are certain limitations. Please check with our Customer Service Center for further details.</p>	<p>\$12 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>	<p>\$20 per office visit for outpatient services</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of non-human or artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> <li>• <i>Transportation, lodging, and living expenses</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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

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

Here are some important things you should keep in mind about these benefits:

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

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Benefit Description		
Inpatient hospital	You pay – High Option	You pay – Standard Option
<p>Room and board, such as:</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations</li> <li>• General nursing care</li> <li>• Meals and special diets</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• Your coinsurance for room and board will also apply to maternity care and to newborn children.</li> <li>• Your physician may prescribe private accommodations or private duty nursing (independent nursing) care if it is medically necessary. If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</li> </ul>	<p>Nothing</p>	<p>10% of daily room rate charges</p>

*Inpatient hospital—continued on next page*

Inpatient hospital <i>(continued)</i>	You pay – High Option	You pay - Standard Option
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Dressings, casts, and sterile trays</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Administration of blood and blood products</li> </ul> <p>Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The conditions for which we will provide hospitalization include hemophilia and heart disease. The need for anesthesia, by itself, is not such a condition. We do not cover dental procedures.</p>	Nothing	Nothing
<ul style="list-style-type: none"> <li>• Diagnostic laboratory tests and X-rays</li> </ul>	Nothing	Nothing
<ul style="list-style-type: none"> <li>• Blood, limited to whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin</li> <li>• Collection, storage, and processing of autologous blood for covered scheduled surgery whether or not the units are used</li> </ul>	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor directed units of blood</i></li> <li>• <i>Custodial care</i></li> <li>• <i>Non-covered facilities</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals, and beds</i></li> <li>• <i>Take home items</i></li> <li>• <i>Private nursing care</i></li> <li>• <i>Any inpatient dental procedures</i></li> <li>• <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

<b>Outpatient hospital or ambulatory surgical center</b>	<b>You pay – High Option</b>	<b>You pay – Standard Option</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Dressings, casts, and sterile trays</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> <li>• Administration of blood and blood products</li> <li>• Pre-surgical testing</li> </ul>	\$12 per surgery	\$20 per surgery
<ul style="list-style-type: none"> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> </ul>	<i>10% of plan allowance</i>	50% of our allowance
<ul style="list-style-type: none"> <li>• Blood, limited to whole blood, red cell products, cryoprecipitates, platelets, plasma, fresh frozen plasma, and Rh immune globulin</li> <li>• Collection, storage and processing of autologous blood for covered scheduled surgery whether or not the units are used</li> </ul>	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor directed units of blood</i></li> <li>• <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Skilled nursing care benefits	You pay – High Option	You pay – Standard Option
<p>Up to 100 days per benefit period when full time care is necessary. A benefit period begins when you enter a hospital or skilled nursing facility and ends when you are not a patient in either a hospital or skilled nursing facility for 60 consecutive days.</p> <p>Services include:</p> <ul style="list-style-type: none"> <li>• Nursing care</li> <li>• Bed and board</li> <li>• Medical social services</li> <li>• Prescribed drugs</li> <li>• Medical supplies</li> </ul> <p>Note: We cover physical and occupational therapies under the physical and occupational therapies benefit. We cover speech therapy under the speech therapy benefit.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals, and beds</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Hospice care	You pay – High Option	You pay – Standard Option
<p>If you are diagnosed with a terminal illness with a life expectancy of six months or less, you may elect hospice care.</p> <p>Hospice care is supportive and palliative care (including family counseling) for a terminally ill member when provided by a Plan approved licensed hospice.</p> <p>Short-term inpatient care is limited to respite care, care for pain control, and acute and chronic symptom management.</p> <p>Note: Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Private duty nursing (independent nursing)</i></li> <li>• <i>Homemaker services</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Ambulance		
<ul style="list-style-type: none"> <li>• Local professional ambulance service when ordered or authorized by a Plan physician</li> </ul>	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Transports that we determine are not medically necessary</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

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## Section 5(d) Emergency services/accidents

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### Here are some important things you should keep in mind about these benefits:

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

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### What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

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### What to do in case of emergency:

If you reasonably believe you have a medical emergency condition and you cannot safely go to a Plan Hospital, call 911 or go to the nearest hospital. If an ambulance comes, tell the paramedics that the person who needs help is a Kaiser Permanente member.

### Emergencies within and outside our service area:

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

When you are in the service area of another Kaiser Permanente plan, you may obtain emergency care services from Kaiser Permanente medical facilities and providers. The facilities will be listed in the local telephone book under Kaiser Permanente. You may also obtain information about the location of facilities by calling the Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Maui or Hawaii, or 877/447-5990 TTY.

Within or outside our service area, benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan facility would result in death, disability, or significant jeopardy to your condition.

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

### Urgent care outside our service area:

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

## How to obtain authorization:

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

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

Benefit Description		
Emergency within our service area	You pay – High Option	You pay - Standard Option
<ul style="list-style-type: none"> <li>• Emergency care at a physician's office</li> <li>• Emergency care at an urgent care center</li> <li>• Emergency care at a hospital, including physicians' services</li> </ul>	\$25 per visit	\$25 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area		
<p>At a non-Plan facility:</p> <ul style="list-style-type: none"> <li>• Emergency care at a physician's office</li> <li>• Emergency care at an urgent care center</li> <li>• Emergency care at a hospital, including physicians' services</li> <li>• Urgent care at an emergency room</li> </ul>	20% of our allowance plus any additional charges which would be required if you received your care from the Plan	20% of our allowance plus any additional charges which would be required if you received your care from the Plan
<p>At a Plan facility:</p> <ul style="list-style-type: none"> <li>• Emergency care in a Kaiser Foundation Hospital in another Kaiser Foundation Health Plan service area</li> </ul> <p>Note: We cover continuing or follow-up care under the travel benefit.</p>	The amount you would be charged if you were a member in that service area	The amount you would be charged if you were a member in that service area

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

<b>Emergency outside our service area</b> <i>(continued)</i>	<b>You pay – High Option</b>	<b>You pay – Standard Option</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care</i></li> <li>• <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Ambulance</b>		
Professional ambulance service (including air ambulance) when medically appropriate.	20% of our allowance	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Transports we determine are not medically necessary</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

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

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When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**Here are some important things you should keep in mind about these benefits:**

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

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Benefit Description		
Mental health and substance abuse benefits	You pay – High Option	You pay – Standard Option
<p>We cover all diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan. The treatment plan may include services, drugs and supplies described elsewhere in this brochure.</p> <p>Notes:</p> <ul style="list-style-type: none"> <li>• We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a Plan provider.</li> <li>• OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another.</li> </ul>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions</p>

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

<b>Mental health and substance abuse benefits</b> <i>(continued)</i>	<b>You pay – High Option</b>	<b>You pay – Standard Option</b>
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or disorders of children, adolescents, and adults. Outpatient services include:</p> <ul style="list-style-type: none"> <li>• Diagnostic evaluation</li> <li>• Crisis intervention and stabilization for acute episodes</li> <li>• Psychological testing necessary to determine appropriate psychiatric treatment</li> <li>• Psychiatric treatment (including individual and group therapy visits)</li> <li>• Medication evaluation and management</li> </ul> <p>Diagnosis and treatment of alcoholism and drug abuse. Outpatient services include:</p> <ul style="list-style-type: none"> <li>• Detoxification (the withdrawal process from physically-addictive drugs and/or alcohol when withdrawal is likely to cause medical or life-threatening complications)</li> <li>• Treatment and counseling (including individual and group therapy visits)</li> </ul> <p>Notes:</p> <ul style="list-style-type: none"> <li>• You may see a Plan outpatient mental health or substance abuse provider without a referral from your primary care physician.</li> <li>• Your Plan provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.</li> </ul>	<p>\$12 per office visit</p>	<p>\$20 per office visit</p>
<ul style="list-style-type: none"> <li>• Inpatient psychiatric or substance abuse care</li> <li>• Hospital alternative services, such as partial hospitalization, day treatment, and intensive outpatient psychiatric treatment programs</li> <li>• Day treatment programs for substance abuse</li> </ul> <p>Note: All inpatient admissions, hospital alternative services, and day treatment programs require approval by a Plan physician.</p>	<p>Nothing</p>	<p>10% of daily room rate charges</p>

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

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

**Limitation**

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

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## Section 5(f) Prescription drug benefits

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**Here are some important things you should keep in mind about these benefits:**

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

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

- **Who can write your prescription.** A Plan authorized prescriber must write the prescription.
- **Where you can obtain them.** You may fill the prescription and receive refills at a Plan pharmacy. The only drugs available through mail order are maintenance drugs and only within our service area.

You may obtain mail order prescription forms at any Plan pharmacy, or call the Kaiser Permanente Automated Refill Center at 808/432-5510 on Oahu or at 866-250-1805 on Maui or Hawaii, Monday - Friday, 8:30 a.m. to 5:00 p.m. You may purchase refills for maintenance drugs for a 90-day consecutive supply by mail order at a \$20 copayment through the Plan's mail order prescription service. Please mail your refill order before you are down to your last 10 days supply. Allow one week to receive your medication for refillable orders. We do not deliver the following drugs through mail order: controlled substances as determined by state and/or federal regulations, bulky items, medications affected by temperature, injectables, and other products or dosage forms identified by the Pharmacy and Therapeutics Committee. We do not send mail order drugs to addresses outside our service area.

- **We use a formulary.** A formulary is a listing of preferred pharmaceutical substances and formulas. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. These preferred drugs are included on our formulary. We use a formulary to determine which drugs to prescribe to you. If the physician specifically prescribes a nonformulary drug because it is medically necessary, the nonformulary drug will be covered.

When generic substitution is permissible (i.e., a generic drug is available and the prescribing physician does not require the use of a brand name drug), but you request the brand name drug, this drug is not covered and you pay member rates.

- **These are the dispensing limitations.** We provide up to a 30-day supply. Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call their Plan pharmacy.
- **When you have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.

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*Covered medications and supplies begin on the next page*

Benefit Description		
Covered medications and supplies	You pay – High Option	You pay - Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that require a physician’s prescription</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Diabetes supplies limited to glucose strips, lancets, and insulin syringes</li> <li>• Amino acid modified products used in the treatment of inborn errors of amino acid metabolism (PKU)</li> <li>• Oral immunosuppressive drugs required after a transplant</li> <li>• Oral travel immunizations</li> <li>• Smoking cessation drugs, including nicotine patches. Coverage is limited to one course of treatment per calendar year, if: <ul style="list-style-type: none"> <li>– the drug is prescribed by a Plan physician; and</li> <li>– the member enrolls in and pays the fees for a Plan approved smoking cessation program</li> </ul> </li> <li>• Insulin</li> </ul>	<p>\$10 per prescription</p>	<p>\$10 per prescription</p>
<ul style="list-style-type: none"> <li>• FDA approved contraceptives <ul style="list-style-type: none"> <li>– Oral contraceptives</li> <li>– Diaphragms</li> <li>– Cervical caps</li> <li>– Injectable contraceptive drugs</li> <li>– Intrauterine devices (IUDs)</li> <li>– Implanted time-release contraceptive drugs</li> </ul> </li> </ul> <p>Note: We will not refund any portion of the copayment if the IUD is removed or spontaneously expelled, or the implanted time-release contraceptive drug is removed before the end of its lifetime.</p>	<p>50% of our allowance</p>	<p>50% of our allowance</p>

*Covered medications and supplies—continued on next page*

Covered medications and supplies <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> <li>• Drugs to treat sexual dysfunction have dispensing limitations. Contact us for details.</li> </ul>	50% of our allowance	50% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs related to non-covered services</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy, except as part of a covered out-of-area emergency</i></li> <li>• <i>Non-prescription drugs</i></li> <li>• <i>Drugs and their associated dose, dosage strengths or dosage forms in the same therapeutic category as a non-prescription drug, that have the same indication as the non-prescription drug, as determined by the Plan Pharmacy and Therapeutics committee</i></li> <li>• <i>Vitamins and nutritional supplements that can be purchased without a prescription</i></li> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs related to enhancing athletic performance (such as weight training and body building)</i></li> <li>• <i>Drugs to shorten the duration of the common cold</i></li> <li>• <i>Any packaging other than the dispensing pharmacy's standard packaging</i></li> <li>• <i>Replacement of lost, stolen, or damaged drugs and accessories</i></li> <li>• <i>Medical supplies (such as dressings and antiseptics), except as listed above</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

## Section 5(g) Special features

Feature	Description
<b>Services from other Kaiser Permanente Plans</b>	<p>When you visit the service area of another Kaiser Permanente plan, you are entitled to receive virtually all the services described in this brochure at any Kaiser Permanente medical office or medical center. You must pay the charges or copayments imposed by the Kaiser Permanente plan you are visiting. You will have to pay the copayments or other charges imposed by the plan you are visiting. If the plan you are visiting has a service that differs from the services of this Plan, you are not entitled to receive that service.</p> <p>Some services covered by this Plan, such as artificial reproductive services and the services of specialized rehabilitation facilities, will not be covered if you receive them in other Kaiser Permanente service areas. If a service is limited to a specific number of visits or days, you are entitled to receive only the number of visits or days covered by this Plan.</p> <p>If you are seeking routine, non-emergent, or non-urgent services, you should call your plan facility in that service area and request an appointment. You may obtain routine follow-up or continuing care from these plans, even when you have obtained the original services in our service area. If you require emergency services as the result of unexpected or unforeseen illness that requires immediate attention, you should go directly to the nearest Kaiser Permanente facility to receive care.</p> <p>At the time you register for services, you will be asked to pay the charges required by the local plan.</p> <p>If you wish to obtain more information about the services available to you from a Kaiser Permanente plan in an area you visit, please call our Customer Service Center at 808/432-5955 on Oahu, or on Maui or Hawaii at 800/966-5955.</p>
<b>Interpretive services</b>	<p>If you need interpretive services during your visit, please ask an English-speaking friend or relative to call our Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Maui or Hawaii.</p>
<b>24 hour advice line</b>	<p>For any of your health concerns, you may talk with a registered nurse 24 hours a day, 7 days a week, who will discuss your treatment options and answer your health questions.</p> <p>During clinic hours, you may call your clinic.</p> <p>During after hours, you may call 808/432-7700 on Oahu or 800/467-3011 on Maui or Hawaii.</p> <p>Hours of operation are:</p> <ul style="list-style-type: none"> <li>• Monday through Friday, 5 p.m. – 8 a.m.</li> <li>• Noon, Saturday, through 8 a.m., Monday</li> <li>• Holidays, all day</li> </ul>

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**Travel benefit**

Kaiser Permanente's travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are temporarily outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency and urgent care benefits and include:

- Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast.
- Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 90 days by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring.
- You pay \$25 for each follow-up or continuing care office visit. We deduct this amount from the payment we make to you.
- We pay no more than \$1200 each calendar year.
- For more information about this benefit call the Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Maui or Hawaii.

Claims should be submitted to Affiliated Care, Kaiser Foundation Health Plan, Inc., 80 Mahalani Street, Wailuku, Hawaii 96793.

*The following are a few examples of services not included in your travel benefits coverage:*

- *Non-emergency hospitalization*
  - *Infertility treatments*
  - *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*
  - *Transplants*
  - *DME*
  - *Prescription drugs*
  - *Home health services*
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<p><b>Flexible benefits option</b></p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative treatment</li> <li>• We review alternative treatment on an outgoing basis</li> <li>• By approving an alternative treatment, we cannot guarantee you will get it in the future</li> <li>• The decision to offer an alternative treatment is solely ours, and we may withdraw it at any time and resume regular contract benefits</li> <li>• Our decision to offer or withdraw alternative treatments is not subject to OPM review under the disputed claims process</li> </ul>
<p><b>Travel assistance</b></p>	<p>In addition to the Kaiser Permanente travel benefit stated above, the Plan will provide travel and medical assistance for Federal members traveling domestically and abroad. Services and products to assure access to appropriate health care services and travel assistance while away from home include:</p> <ul style="list-style-type: none"> <li>• Pre-trip information</li> <li>• Precertification assistance for inpatient hospital stays</li> <li>• Case management assistance</li> <li>• Translation services</li> <li>• Provider location assistance</li> <li>• Medical transport assistance</li> <li>• Emergency medication assistance</li> <li>• Lost document assistance</li> <li>• Emergency messaging</li> <li>• Lost baggage assistance</li> </ul> <p>The cost for uninsured services will be paid by the member including but not limited to: transportation costs, assistance for unattended minors, repatriation of remains, lost document costs, and medical evacuation.</p> <p>Members who need assistance should contact World Access. If members are traveling:</p> <ul style="list-style-type: none"> <li>• within the United States, Puerto Rico and the Virgin Islands, call toll free at 866/221-7870;</li> <li>• worldwide (outside US, Puerto Rico or Virgin Islands), call collect at 804/673-1497.</li> </ul> <p>Both numbers are available 24 hours a day; 365 days a year.</p>

## Section 5(h) Dental benefits

**Here are some important things you should keep in mind about these benefits:**

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we pay them only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

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<b>Accidental injury benefit</b>	<b>You pay - High Option</b>	<b>You pay – Standard Option</b>
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Any other services are provided as described below.	\$12 per office visit	\$20 per office visit
<b>Dental benefit</b>		

We cover dental benefits. You may choose your dentist and your out-of-pocket expenses will be based on your dentist’s eligible fees and your plan benefits. During your first appointment, advise your dentist that you are covered by the Kaiser Foundation Health Plan Federal Dental Care Program, and present your Hawaii Dental Service (HDS) member identification card to your dentist.

If your dentist must perform procedures totaling \$400 or more, your dentist may submit a claim form to HDS before providing services to you. Upon HDS’s approval, your dentist should explain your treatment plan, the dollar amount your dental benefits plan will cover, and the amount you will pay before performing the services.

Before you receive treatment, you should discuss the total charges and your financial obligations with your dentist. You are financially responsible for any remaining balance between your dentist’s eligible fee and the HDS payment. Eligible fee is the maximum amount an HDS Member Dentist agrees to accept for a dental procedure. Participating HDS dentists are referred to as HDS Member Dentists. Non-participating HDS dentists are referred to as Non-Member Dentists.

<b>Service</b>	<b>You pay - High Option</b>	<b>You pay – Standard Option</b>
We cover diagnostic and preventive care services when provided through Hawaii Dental Service: <ul style="list-style-type: none"> <li>• Examinations – once every calendar year</li> <li>• Bitewing X-rays – twice every calendar year</li> </ul>	Nothing	Nothing

*Dental benefit—continued on next page*

Dental benefit <i>(continued)</i>	You pay – High Option	You pay – Standard Option
<ul style="list-style-type: none"> <li>• Other X-rays – limited to one full mouth series of X-rays (including bitewings) once every three years</li> <li>• Prophylaxis (cleaning) – once every calendar year</li> <li>• Stannous fluoride – once every calendar year and for dependent children only</li> <li>• Palliative treatment – for relief of pain</li> </ul>	20% of eligible fees	20% of eligible fees
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic dental services</i></li> <li>• <i>Prosthetic services or devices (including crowns and bridges) started prior to the date you became eligible under this Program</i></li> <li>• <i>Orthodontic services</i></li> <li>• <i>Dental services not listed as covered</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

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

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan physician determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Section 5(d)), services under the Travel Benefit (see Section 5(g)), and services received from other Kaiser Permanente plans (see Section 5(g));
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service; or
- Services provided or arranged by criminal justice institutions for members confined therein.

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## Section 7. Filing a claim for covered services

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When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

### **Medical and hospital benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 808/243-6610 on Maui or 877/975-3805 on Oahu or Hawaii.

When you must file a claim – such as for services you receive outside of the Plan's service area – submit it on the HCFA-1500 or a claim form that includes the information shown below.

Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- Follow up services rendered out-of-area
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

#### **Submit your claims to:**

Affiliated Care - Claims Department  
Kaiser Foundation Health Plan, Inc.  
80 Mahalani Street  
Wailuku, HI 96793

### **Deadline for filing your claim**

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

### **When we need more information**

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

### **If you have a malpractice claim**

If you have a malpractice claim because of services you did receive, or did not receive, from a Plan provider, you must submit the claim to binding arbitration. The Plan has the information that describes the arbitration process. Contact our Customer Service Center at 808/432-5955 on Oahu, or at 800/966-5955 on Maui or Hawaii for copies of our requirements. These will explain how you can begin the binding arbitration process.

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## Section 8. The disputed claims process

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Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for pre-authorization/prior approval:

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: Kaiser Foundation Health Plan, Inc., Affiliated Care/Appeals, 501 Alakawa Street, Honolulu, HI 96817, or by fax at 808/432-7518 or by email to <a href="mailto:kphawaii.appeals@kp.org">kphawaii.appeals@kp.org</a>; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</li></ol>
<b>3</b>	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

## The disputed claims process (*continued*)

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

**5** OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at the Expedited Review Hotline at 866/233-2851 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payer, and you received your services from Plan providers, we may bill the primary carrier.

### What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

- **Should I enroll in Medicare?**

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

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

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

- **If you enroll in Medicare Part B**

If you enroll in Medicare Part B, we require you to assign your Medicare Part B benefits to the Plan for its services.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. We will not waive any of your copayments.

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

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

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

<b>Primary Payer Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payer for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and ... You have FEHB coverage on your own or through your spouse who is also an active employee You have FEHB coverage through your spouse who is an annuitant	✓	✓
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>		
	✓	

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

- **Medicare Advantage**

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

If you enroll in a Medicare Advantage plan, the following options are available to you:

**This Plan and our Medicare Advantage plan:** You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we waive or lower some of our copayments and coinsurance for your FEHB and Medicare coverage. There is no additional premium to enroll in Senior Advantage. If you would like information about our Medicare Advantage plan, please call 808/432-5955 on Oahu and 800/966-5955 on Maui or Hawaii. Your Kaiser Permanente Senior Advantage-FEHP benefits that we lowered or waived are:

### **High Option**

- Office visits: \$5 copayment for physicians and other health professionals visits
- Lab, X-ray, and diagnostic services: \$0
- Emergency care: \$25 for each emergency visit
- Preventive services visits: \$5 copayment
- Routine physical and hearing exams: \$5 copayment for each routine physical and hearing exam
- Immunizations: Pneumococcal pneumonia, flu, and hepatitis B vaccines at no charge
- Urgently needed care: \$5 copayment for each visit to a Plan facility
- One routine eye exam each year: \$5 copayment
- Durable medical equipment: 20% copayment
- External prosthetics: 20% copayment
- Blood, blood transfusions, and blood products: \$0
- Dialysis: \$0
- Manual manipulation of the spine to correct subluxation: \$5 copayment
- Intraocular lens after cataract surgery: 20% copayment

### **Standard Option**

- Office visits: \$12 copayment for physicians and other health professionals visits
- Lab, X-ray, and diagnostic services: \$0
- Emergency care: \$25 for each emergency visit
- Preventive services visits: \$12 copayment
- Routine physical and hearing exams: \$12 copayment for each routine physical and hearing exam
- Immunizations: Pneumococcal pneumonia, flu, and hepatitis B vaccines at no charge
- Urgently needed care: \$12 copayment for each visit to a Plan facility
- One routine eye exam each year: \$12 copayment
- Durable medical equipment: 20% copayment
- External prosthetics: 20% copayment
- Blood, blood transfusions, and blood products: \$0
- Dialysis: \$0
- Manual manipulation of the spine to correct subluxation: \$12 copayment
- Intraocular lens after cataract surgery: 20% copayment

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

**Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare managed care service area.

## **TRICARE and CHAMPVA**

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

**Suspended FEHB coverage to enroll in TRICARE or CHAMPVA:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

## **Workers' Compensation**

We do not cover services that:

- You need because of a workplace related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

## **Medicaid**

When you have this Plan and Medicaid, we pay first.

**Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

## **When other Government agencies are responsible for your care**

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

## **When others are responsible for injuries**

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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

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<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	<p>(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine.</p> <p>(2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.</p> <p>Custodial care that lasts 90 days or more is sometimes known as Long term care.</p>
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.
<b>Experimental or investigational services</b>	<p>We consider a service, supply or drug to be experimental when the service or supply, including a drug:</p> <ol style="list-style-type: none"><li>(1) has not been approved by the FDA; or</li><li>(2) is the subject of a new drug or new device application on file with the FDA; or</li><li>(3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or</li><li>(4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or</li><li>(5) is subject to the approval or review of an Institutional Review Board; or</li><li>(6) requires an informed consent that describes the service as experimental or investigational.</li></ol> <p>We do not cover a service, supply, or drug that we consider experimental.</p> <p>This Plan and our Medical Group carefully evaluate whether a particular therapy is safe and effective or offers a degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical literature.</p>
<b>Group health coverage</b>	Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

**Medically necessary**

All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of your receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.

**Our allowance**

The amount we use to determine your coinsurance. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, it is either the amount we have negotiated with the non-Plan provider, or if we do not have a negotiated amount, the amount that we believe is usual and customary for the service or supply, compared to the billed charges. Our allowance is based upon the reasonableness of the billed charges. If the billed charges exceed what we believe is reasonable, you may be responsible for the excess over our allowance in addition to your coinsurance.

**Us/We**

Us and we refer to Kaiser Foundation Health Plan, Inc., Hawaii Region.

**You**

You refers to the enrollee and each covered family member.

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## Section 11. FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See [www.opm.gov/insure](http://www.opm.gov/insure). Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children’s Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2004 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

### **When you lose benefits**

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, [www.opm.gov/insure](http://www.opm.gov/insure).

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from [www.opm.gov/insure](http://www.opm.gov/insure). It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB website at [www.opm.gov/insure/health](http://www.opm.gov/insure/health); refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

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## Section 12. Two Federal Programs complement FEHB benefits

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### Important information

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

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

- **What is an FSA?**

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

There are two types of FSAs offered by FSAFEDS:

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

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

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

- Covers eligible dependent care expenses incurred so you and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

**What is SHPS?**

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

**Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

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

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

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

**• What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 14 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

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

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

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

- **Tax savings with an FSA**

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

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

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

- **Tax credits and deductions**

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

- Health care expenses**

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

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

- Dependent care expenses**

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

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

- **Does it cost me anything to participate in FSAFEDS?** Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us** To learn more or to enroll, please visit the **FSAFEDS website** at [www.FSAFEDS.com](http://www.FSAFEDS.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: [FSAFEDS@shps.net](mailto:FSAFEDS@shps.net)
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

## The Federal Long Term Care Insurance Program

- **It's important protection** Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?
  - **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
  - **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
  - **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
  - **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
  - **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To find out more and to request an application** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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## Index

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

- 24 hour nurse line .....51
- Accidental injury to sound natural  
teeth.....54
- Allergy tests.....23
- Allowance, our .....67
- Alternative treatments.....28
- Ambulance.....41, 44
- Anesthesia .....6, 31, 36
- Autologous bone marrow transplant.....35
- Biopsies .....32
- Blood and blood plasma .....38, 39
- Breast cancer screening .....19
- Casts .....38, 39
- Catastrophic protection out-of-pocket  
maximum.....77, 78
- Changes for 2005.....9
- Chemotherapy .....24
- Chiropractic .....28
- Claims.....57, 58, 62, 69, 73
- Coinurance.....14, 57, 66, 67, 73
- Congenital anomalies .....31, 33
- Contraceptive drugs and devices .....22, 49
- Coordination of benefits .....60
- Covered providers .....11
- Customer Service Center.....7, 10, 11, 12,  
28, 35, 42, 51, 52, 57
- Deductible .....14, 66, 73
- Definitions.....66, 77, 78
- Dental care.....54, 77, 78
- Diabetes .....14, 26, 29, 49
- Diagnostic services... 17, 18, 38, 39, 77, 78
- Disputed claims review .....58
- Donor expenses (transplants).....35
- Dressings .....38, 39
- Drugs, prescription .....48, 49, 50
- Durable medical equipment (DME) .....27
- Educational classes and programs .....29
- Effective date of enrollment .....69
- Emergency.....42, 43, 57, 77, 78
- Experimental or investigational .....56, 66
- Eyeglasses .....25
- Family planning.....22
- Fecal occult blood test.....18
- Flexible benefits option .....53
- Fraud .....3, 4
- General exclusions .....56
- Hearing services .....25
- Home health services.....27
- Hospice care .....41
- Hospital... 5, 6, 37, 38, 39, 57, 61, 63, 77,  
78
- Immunizations .....20
- Infertility .....23
- Inpatient hospital benefits.....37, 38
- Insulin.....49
- Laboratory and pathological services... 18,  
38, 39
- Magnetic Resonance Imagings (MRI's) .18
- Mail order prescription drugs .....48
- Mammograms .....19
- Maternity benefits .....21, 22
- Medicaid.....65
- Medically necessary .....67
- Medicare.....60, 61, 62, 63
  - Medicare Advantage .....63
  - Original .....61, 63
- Members
  - Associate .....79
  - Family .....68
- Mental conditions/substance abuse  
benefits .....45, 46, 47
- Newborn care .....17, 21
- Non-FEHB benefits.....14
- Nurse
  - Nurse Anesthetist .....38
  - Nurse Practitioner.....10
  - Registered Nurse.....51
- Nursery charges.....21
- Obstetrical care.....21
- Occupational therapy.....24
- Oral and maxillofacial surgery .....34
- Orthopedic devices.....26
- Out-of-pocket expenses.....14, 61
- Oxygen.....38, 39
- Physical examinations.....20
- Precertification .....53, 59
- Prescription drugs... 48, 49, 50, 57, 63, 77,  
78
- Preventive care, adult .....18, 19, 20
- Preventive care, children .....20, 21
- Prior approval.....12, 58, 59
- Prosthetic devices.....26
- Psychotherapy .....47
- Radiation therapy .....24
- Renal dialysis.....24
- Room and board .....37
- Second surgical opinion .....17
- Services from other Kaiser Permanente  
Plans.....51
- Skilled nursing care benefits .....17, 27, 40
- Smoking cessation.....30, 49
- Speech therapy .....25
- Splints .....26
- Sterilization procedures.....32
- Subrogation .....65
- Substance abuse .....45, 46, 47, 77, 78
- Surgery .....6, 33
  - Anesthesia.....36
  - Oral .....34
  - Outpatient .....39
  - Reconstructive .....33
- Syringes .....49
- Temporary continuation of coverage  
(TCC).....69, 70
- Transplants.....35
- Travel benefit .....52
- Treatment therapies .....24
- TRICARE and CHAMPVA .....65
- Vision services .....25, 77, 78
- Well child care .....20
- Workers' Compensation.....65
- X-rays.....18, 38, 39, 55

## Summary of benefits for Kaiser Foundation Health Plan, Inc. – Hawaii Region High Option – 2005

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office .....	\$12 per office visit	17 - 30
Services provided by a hospital:		
• Inpatient .....	Nothing	37 - 38
• Outpatient .....	\$12 per visit	39
Emergency benefits		
• In-area.....	\$25 per visit	43
• Out-of-area .....	20% of our allowance	43
Mental health and substance abuse treatment .....	Regular cost sharing	45 - 47
Prescription drugs .....	\$10 per prescription	48 - 50
Dental care .....	Various copayments based on procedure rendered	54 - 55
Vision care .....	\$12 per office visit	25
Special features: Services from other Kaiser Permanente Plans; Interpretive services; 24 hour advice line; Travel benefit; Flexible benefits option; Travel assistance		51 - 53
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) .....	Nothing after \$1,500/Self Only or \$4,500/Family enrollment per year  Some costs do not count toward this protection	14

## Summary of benefits for Kaiser Foundation Health Plan, Inc. – Hawaii Region Standard Option – 2005

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office .....	\$20 per office visit	17 - 30
Services provided by a hospital:		
• Inpatient .....	10% of daily room rate charges	37 - 38
• Outpatient .....	\$20 per visit	39
Emergency benefits		
• In-area.....	\$25 per visit	43
• Out-of-area .....	20% of our allowance	43
Mental health and substance abuse treatment .....	Regular cost sharing	45 – 47
Prescription drugs .....	\$10 per prescription	48 - 50
Dental care .....	Various copayments based on procedure rendered	54 - 55
Vision care .....	\$20 per office visit	25
Special features: Services from other Kaiser Permanente Plans; Interpretive services; 24 hour advice line; Travel benefit; Flexible benefits option; Travel assistance		51 - 53
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) .....	Nothing after \$1,500/Self Only or \$4,500/Family enrollment per year  Some costs do not count toward this protection	14

## 2005 Rate Information for Kaiser Foundation Health Plan, Inc. – Hawaii Region

**Non-Postal rates** apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

**Postal rates** apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	631	\$128.07	\$42.69	\$277.4	\$92.49	\$151.55	\$19.21
High Option Self and Family	632	\$275.35	\$91.78	\$596.59	\$198.86	\$325.83	\$41.30
Standard Option Self Only	634	\$99.43	\$33.14	\$215.43	\$71.81	\$117.66	\$41.30
Standard Option	635	\$213.77	\$71.26	\$463.18	\$154.39	\$252.96	\$32.07