Kaiser Foundation Health Plan, Inc.
A NONPROFIT HEALTH PLAN - HAWAII REGION

2019 Summary of Important Changes for Contract Renewals for the Kaiser Permanente Group Plan

(These changes are subject to regulatory approval)

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

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

For specific questions about benefits, you may call our Customer Service Center at 1-800-966-5955.

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

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

CONTRACT CHANGES:

These changes become effective on your employer's contract renewal date, unless specified otherwise below.

1. **Routine newborn nursery care.** All newborns will be covered for routine newborn nursery care services for the first 48 or 96 hours after birth. (Previously, routine newborn nursery care services were covered only when the newborn is enrolled.)
2. **Artificial insemination.** Artificial insemination (intrauterine insemination) will no longer be covered as a stand-alone fertility treatment. Artificial insemination will be a medically necessary procedure under the in vitro fertilization (IVF) benefit. (Previously, artificial insemination was an independent clause not placed with IVF benefit.)

If your plan is KP Gold $15, KP Gold $17, or KP Gold I $20, see also "Plan-Specific Cost Share Changes" section on the next page.

REORGANIZED CONTENT

The content is reorganized in the new Guide and language may appear different (from the former format of benefit summary, Benefit Schedule and Service Agreement). The meaning and intent continue to be the same. Examples:

1. **Total Care Services.** In 2016, KP implemented benefits which are covered with a single Cost Share. Our Guide defines these benefits as Total Care Services, and organizes them into one section. When a member receives a covered benefit in a Total Care Service setting, member only pays a single Cost Share. The seven Total Care Service settings are inpatient Hospital, outpatient surgery and procedures in a hospital-based setting or ambulatory surgery center (ASC), Emergency, observation, Skilled Nursing Facility, dialysis, and radiation therapy. (Previously, the single Cost Share was not clearly described in the multiple sections of the benefit summary and Benefit Schedule.)
2. **Preventive screenings and care.** Our Guide organizes the various preventive screenings and care into one section. (Previously, the screenings and care were described in multiple sections of the benefit summary and Benefit Schedule.)
3. **Special services for women.** Our Guide features the special services for women in one section. This section includes annual gynecological, screenings, family planning infertility consultation, in vitro fertilization, maternity, pregnancy termination and sterilization. (Previously, these services were described in multiple sections of the benefit summary and Benefit Schedule.)
4. **Benefit and payment chart.** A benefit and Cost Share payment chart is conveniently located in the front of our Guide. The member's benefits and Cost Share are easy to find in this chart, and includes a page number for more

information in Chapter 3 in our Guide. *Chapter 3: Benefit Description* contains the corresponding benefit descriptions and details. (Previously, Cost Shares were listed within benefit descriptions, which are described throughout the benefit summary and Benefit Schedule.)

5. **Services not covered.** The exclusions are located within *Chapter 4: Services Not Covered*. (Previously, exclusions were listed for specific benefits in the Benefit Schedule, and general exclusions for all benefits were listed in the Service Agreement.)

PLAN SPECIFIC COST SHARE CHANGES

These changes become effective on your employer's contract renewal date, unless specified otherwise below.

KP Gold $15 Plan

- Annual copayment maximum for medical services will be $2,500 per member/$5,000 for a family of 2 or more members (was $2,200/$4,400).
- Annual deductible for medical services will be $250 per member/$500 for a family of 2 or more members (was $200/$400).
- Annual prescription drug copayment maximum (on pharmacy dispensed drugs) will be $5,400 per member/$10,800 for a family of 2 or more members (was $5,150/$10,300).
- Annual prescription drug deductible for brand and specialty drugs will be $700 per member/$1,400 for a family of 2 or more members (was $500/$1,000).

KP Gold $17 Plan

- Annual prescription drug copayment maximum (on pharmacy dispensed drugs) will be $4,000 per member/$8,000 for a family of 2 or more members (was $3,650/$7,300).

KP Gold I $20 Plan

- Annual prescription drug copayment maximum (on pharmacy dispensed drugs) will be $5,400 per member/$10,800 for a family of 2 or more members (was $4,850/$9,700).
- Annual prescription drug deductible for brand and specialty drugs will be $1,000 per member/$2,000 for a family of 2 or more members (was $700/$1,400).

Kaiser Permanente Group Plan Benefit and Payment Chart

W.W. GRAINGER, INC.

About this chart

This benefit and payment chart:

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

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

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

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

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

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

Description	Cost Share
Annual Copayment Maximum	
Member	$2,500 per calendar year
Family Unit (3 or more members)	$7,500 per calendar year
Annual Deductible	
Member	None
Family Unit	None
Routine and Preventive	
Health Education and Disease Management	
•Physician Visits	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Tobacco Cessation and Counseling Sessions	None
•Health education publications	None
•Healthy Living Classes	Applicable class fees
Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))	None
•Office visit for (CDC) Immunizations	None
•Office visit for Travel Immunization	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Unexpected Mass Population Immunizations	50% of all Applicable Charges
Office Visits	
•Well-Child Care	None
•Annual Preventive Care (physical exam) Office Visit	None
•Hearing Exam (for correction)	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Vision Exam (for glasses)	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
Preventive Screenings and Care	None
Total Health Assessment (www.kp.org)	None
Special Services for Women	
Preventive Care	
•Annual Gynecological Exam	None
•Mammography (screening)	None
•Pap Smears (cervical cancer screening)	None
Family Planning Visits	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
Infertility Consultation	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
In Vitro Fertilization	20% of applicable charges
Maternity	
•Maternity Care–routine prenatal visits	None
•Maternity Care–delivery	10% of applicable charges
•Maternity Care–one postpartum visit	None

Description	Cost Share
•Maternity and Newborn Length of Stay	10% of applicable charges
•Breast Pump	None
Contraceptive Drugs and Devices	See Prescription Drugs
Pregnancy Termination	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Services
Voluntary Sterilization (including tubal ligation)	
•Medical Office	None
•Total Care Settings	Included in Total Care Settings
Special Services for Men	
Prostate Specific Antigen (screening)	$10 per day
Vasectomy	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Settings
Online Care	
My Health Manager (www.kp.org)	None
Office Visits	
Office Visits	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Routine pre-surgical and post-surgical	None
Urgent Care Visits	
•Within Service Area (Primary Care)	$20 per visit
•Within Service Area (Specialty Care)	$20 per visit
•Outside Service Area	20% of Applicable Charges
Dependent Child Outside of Service Area	
•Routine Primary Care	$20 per visit
•Basic laboratory and general imaging	$10 per visit
•Testing	20% of applicable charges
•Self-administered drug prescriptions	20% of applicable charges
House Calls	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
Telehealth	$20 per visit; Cost share will vary depending on service.

Description	Cost Share
Laboratory, Imaging, and Testing	
Laboratory	
•Basic	$10 per day
•Specialty	$10 per day
Imaging	
•Basic	$10 per day
•Specialty	$10 per day
Testing	
•Allergy Testing	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Skilled-Administered Drugs	20% of applicable charges
•Diagnostic Testing	20% of applicable charges
Surgery	
Outpatient Surgery and Procedures	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Services
Reconstructive Surgery	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Covered Mastectomy	10% of applicable charges
•Total Care Settings	Included in Total Care Services
Total Care Services	
You only pay a single Cost Share for covered benefits you receive in the following Total Care Service settings:	
Inpatient Hospital Services	10% of applicable charges
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	10% of applicable charges
Emergency Services	$100 per visit in area, $100 per visit out of area.
Observation	10% of applicable charges
Skilled Nursing Facility	10% of applicable charges, up to 120 days per year
Dialysis	
•Dialysis	20% applicable charges
•Equipment, Training and Medical Supplies for home Dialysis	None
Radiation Therapy	20% of applicable charges
Ambulance	
Air Ambulance	20% of applicable charges
Ground Ambulance	20% of applicable charges
Physical, Occupational, and Speech Therapy	
Physical and Occupational Therapy	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Home Health Care	None
•Total Care Settings	Included in Total Care Services
Speech Therapy	
•Primary Care	$20 per visit

Description	Cost Share
•Specialty Care	$20 per visit
•Home Health Care	None
•Total Care Settings	Included in Total Care Services

Home Health Care and Hospice Care

Home Health Care	None
Hospice Care	None
Physician Visits	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit

Chemotherapy

•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Services

Internal, External Prosthetics Devices and Braces

Implanted Internal Prosthetics, Devices and Aids	
•Medical Office	None
•Total Care Settings	Included in Total Care Services
External Prosthetics Devices	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Braces	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services

Durable Medical equipment

Durable Medical equipment	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Oxygen (for use with DME)	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Repair or Replacement	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Diabetes Equipment	50% of Applicable Charges
Home Phototherapy equipment	None

Behavioral Health–Mental Health and Substance Abuse

Mental Health Care	
•Medical Office	$20 per visit
•Total Care Settings	Included in Total Care Services
Chemical Dependency Care	
•Medical Office	$20 per visit

Description	Cost Share
•Total Care Settings	Included in Total Care Services
Autism Care	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit

Transplants

Transplant Care for Transplant Recipients	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Services
Transplant Care for Transplant Donors (based on health plan approval)	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Services
•Related Prescription Drugs	See prescription drugs in this *Benefit Summary*
Transplant Evaluations	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit

Prescription Drug

Skilled Administered Drugs	20% of applicable charges , Included in Total Care Services
Self-Administered Drugs	If your employer has purchased a drug rider, coverage will be as specified in your drug rider following this *Benefit Summary*
Chemotherapy Drugs	
•Chemotherapy Infusion or Injections (Skilled Administered Drugs)	20% of applicable charges
•Chemotherapy–Oral Drugs (Self-Administered Drugs)	20% of applicable charges or as specified in applicable drug rider
Contraceptive Drugs and Devices	Greater of 50% of applicable charges; or minimum price as determined by Pharmacy Administration
Diabetic Supplies	Greater of 50% of Applicable Charges; or minimum price as determined by Pharmacy Administration
Tobacco Cessation Drugs and Products	None (up to 30-day supply)

Drug Therapy Care

Growth Hormone Therapy	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Skilled-Administered Drug	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Home IV/Infusion therapy	
•Therapy and IV drugs	None
•Self-Administered Injections	See prescription drugs in this Benefit Summary

Description	Cost Share
Inhalation Therapy	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Services

Miscellaneous Medical Treatments

Blood and Blood Products	
•Medical Office	None
•Rh Immune Globulin	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Dental Procedures for Children	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Services
Hearing Aids	
•Hearing Test	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Appliances	60% of applicable charges for lowest priced model, per ear, every 36 months
Hyperbaric Oxygen Therapy	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Services
Materials for Dressings and Casts	Cost Share will vary upon place of service
•Total Care Settings	Included in Total Care Services
Medical Foods	20% of Applicable Charges
Medical Social Services	None
Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
Pulmonary Rehabilitation	
•Primary Care	$20 per visit
•Specialty Care	$20 per visit
•Total Care Settings	Included in Total Care Services

Description	Cost Share
Additional services	
Prescribed Drugs, Self-Administered Generic Maintenance Drugs: $3 per prescription Other Generic Drugs: $10 per prescription Brand-Name Drugs: $45 per prescription Specialty drugs: $200 **Prescription drug mail-order incentive**	**4-Tier Prescription drug 3/10/45/200** Two drug copayments for a 90-consecutive-day supply
Special Services for Women Artificial insemination (intrauterine insemination)	Same infertility cost share listed in the Benefit Summary in the front of this Guide
Optical services	Not included
Dental services	Not included
Complementary Alternative Medicine	Not included
Fit Rewards (per calendar year)	$200 gym membership or $10 home fitness program

Health Plan believes coverage under this Evidence of Coverage is a ”grandfathered health plan” under the Patient Protection and Affordable Care Act. As permitted by the Patient Protection and Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Questions regarding grandfathered health plans may be directed to Member Services.