YOUR INTRODUCTION TO KAISER PERMANENTE

Added Choice®
MEMBER HANDBOOK

Kaiser Permanente. thrive

Give yourself the power of choice.
This *Added Choice Member Handbook* is not intended for and does not apply to the following members:

- Kaiser Permanente HMO group plan members
- Kaiser Permanente Federal Employees Health Benefits Program members
- Kaiser Permanente for Individuals and Families Plan members
- Kaiser Permanente Medicare Cost members
- Kaiser Permanente QUEST Integration members
- Kaiser Permanente Senior Advantage members

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

This handbook provides general information, not medical advice, nor does it provide information concerning the scope of your coverage. For complete details on your benefit coverage, including exclusions, limitations, and plan terms, please refer to your employer or group administrator’s applicable *Benefits Summary, Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders* (collectively known as the *Service Agreement*), and the Kaiser Permanente Insurance Company (*KPIC Group Policy and Certificate of Insurance*). The *Service Agreement* and *KPIC Group Policy* are the legally binding documents between Kaiser Foundation Health Plan, Inc. (KFHP), KPIC, and your employer. In the event of ambiguity, or a conflict between this *Member Handbook* and the *Service Agreement* and *KPIC Group Policy*, the *Service Agreement* and *KPIC Group Policy* shall control.

**Information in this handbook is current as of September 2016 and may be subject to change without notice.**
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Thank you for choosing Kaiser Permanente. At Kaiser Permanente, we believe there’s no better choice than choosing good health. That’s why we provide you with the tools you need to get healthy and stay healthy. To help you get started, this handbook contains information about selecting a doctor, receiving care, filing claims, using pharmacy services, and making the most of your coverage. Please keep it handy as a reference tool.

YOUR CHOICE FOR GOOD HEALTH

Kaiser Permanente Added Choice® is a point-of-service health plan brought to you by Kaiser Foundation Health Plan, Inc. (Health Plan), and Kaiser Permanente Insurance Company (KPIC). With Added Choice, you get the flexibility you need and the choice of physicians you want. You and your family have the freedom to receive care from Kaiser Permanente providers, contracted providers, and non-contracted providers in your community. With providers and facilities located throughout the state of Hawaii, chances are you’ll find us near your work or home. And, in most of our locations, all the services you need are available under one roof — so you don’t need to run all over town to get routine care.

At Kaiser Permanente, not only do we treat you for illnesses and injuries, we also want you to thrive. Our doctors are committed to you — mind, body, and spirit. Our primary and specialty care doctors work as a team alongside nurses, pharmacists, and other health care professionals. Our electronic health records system lets our in-network health care providers look up your Kaiser Permanente medical record right when they need it. It allows them to immediately order additional services for you within Kaiser Permanente.

LET’S GET STARTED

We’re delighted that you’ve chosen us as your partner in health, and we’re excited about helping you and your family lead healthier lives. So once again, thank you for choosing Kaiser Permanente. We look forward to taking care of you and your family throughout the coming years.
IN HAWAII

Added Choice Helpline........1-800-238-5742
• Press 1 for claims
  (Monday–Friday, 4 a.m.–3 p.m.)
• Press 2 for precertification
  (24 hours a day, 7 days a week)
• Press 3 for member services
  (Monday–Friday, 8 a.m.–5 p.m.;
  Saturday, 8 a.m.–noon)

Kaiser Permanente After-Hours Nurse Advice Line
Oahu.............................................808-432-7700
Neighbor islands ...................... 1-800-467-3011
TTY for the hearing/speech impaired
toll free ........................................711
• Monday–Friday, 5 p.m.–8 a.m. (next day)
• Weekends and holidays, 24 hours

Kaiser Permanente After-Hours Care
Moanalua Medical Center
Monday–Friday, 5–10 p.m.
Weekends and holidays, 8 a.m.–10 p.m.
Please call 808-432-7700 to make an appointment before your visit.

Maui Lani Medical Office
Monday–Friday, 5–8 p.m.
Saturday, noon–5 p.m.
Sunday and most holidays, 8 a.m.–5 p.m.
Closed on Christmas and New Year’s Day.
Please call 808-243-6050 to make an appointment before your visit.

Hawaii Poison Hotline..........1-800-222-1222
Open 24 hours a day, 7 days a week

Hawaii State Department of Commerce
and Consumer Affairs – Insurance Division
Oahu.............................................808-586-2790
Maui.......................................... 808-984-2400
Hawaii........................................ 808-974-4000
Kauai......................................... 808-274-3141
Lanai and Molokai .....................1-800-468-4644

Occupational Health Services
For more information or to schedule an appointment, call:
Oahu .............................................808-432-2208
Neighbor islands, toll free........1-844-685-1395

Prescription Orders
Order most prescriptions online at kp.org/pharmacycenter
Order most medications (new and refills) by phone, 24 hours a day, 7 days a week:
808-643-RxRx (808-643-7979)

Kaiser Permanente Member Services
1-800-966-5955
TTY for the hearing/speech impaired
toll free ........................................711
• Monday–Friday, 8 a.m.–5 p.m.
• Saturday, 8 a.m.–noon

OUTSIDE HAWAII

Kaiser Permanente offers medical care in eight states and the District of Columbia. You may receive certain services as a visiting member when you travel to one of the following areas. For information about medical care, please call during regular business hours. Kaiser Permanente service areas are subject to change at any time.

CALIFORNIA

Northern and Southern California Regions
1-800-464-4000
711 (TTY)

Open 24 hours a day, 7 days a week.
Closed holidays and at 10 p.m. on Christmas Eve, New Year’s Eve, and the day after Thanksgiving.

Note: If you are seeking services from a contracted non–Kaiser Permanente provider in Coachella Valley (Palm Desert, Palm Springs, Desert Hot Springs, Indio) in California, you may be required to contact your primary care physician in your home area to get an approved referral.
COLORADO

Denver/Boulder area
303-338-3800

Northern Colorado area
(including Loveland, Greeley, Fort Collins)
1-800-632-9700

Southern Colorado area
(including Colorado Springs, Pueblo, and the Cañon City and Woodland Park communities)
1-888-681-7878
711 (TTY for all Colorado service areas)
Monday–Friday, 8 a.m.–5 p.m.

Note: Members visiting the Colorado area can use Kaiser Permanente medical offices but cannot access networked providers in Northern Colorado. In Southern Colorado, members can access affiliated providers but are limited to which ones based on their plan.

DISTRICT OF COLUMBIA

Mid-Atlantic States Region
301-468-6000 (from D.C. metro area)
1-800-777-7902 (from other areas)
711 (TTY)
Monday–Friday, 7:30 a.m.–5:30 p.m.

GEORGIA

Atlanta Metro area
404-261-2590 (from Atlanta metro area)
1-888-865-5813 (from other areas)
711 (TTY)
Monday–Friday, 7 a.m.–7 p.m.

MARYLAND

Mid-Atlantic States Region
Baltimore and suburban D.C. area
301-468-6000 (from D.C. metro area)
1-800-777-7902 (from other areas)
711 (TTY)
Monday–Friday, 7:30 a.m.–5:30 p.m.

OREGON

Northwest Region
503-813-2000 (from Portland)
1-800-813-2000 (from other areas)
711 (TTY)
1-800-324-8010
(language interpreter services)
Monday–Friday, 8 a.m.–6 p.m.

VIRGINIA

Mid-Atlantic States Region
Northern area
1-800-777-7902
711 (TTY)
Monday–Friday, 7:30 a.m.–5:30 p.m.

WASHINGTON STATE

Northwest Region
Southwest area
1-800-813-2000
711 (TTY)
1-800-324-8010
(language interpreter services)
Monday–Friday, 8 a.m.–6 p.m.

Group Health Cooperative (GHC)
Member Services (all areas)
1-888-901-4636
711 (TTY)
Monday–Friday, 8 a.m.–5 p.m.

Note: Phone numbers beginning with 1-800, 1-866, 1-877, or 1-888 are toll free. TTY numbers are for the hearing/speech impaired.
ABOUT THE ADDED CHOICE HELPLINE

The Added Choice Helpline can help you understand your health plan. When you have questions, just give us a call at 1-800-238-5742.

For frequently asked questions and concerns, choose from the following options:

- Press 1 for information about nonemergency claims. (Monday–Friday, 4 a.m.–3 p.m.)
- Press 2 for precertification of specified contracted and non-contracted provider services. (24 hours a day, 7 days a week)
- Press 3 for a local Kaiser Permanente Member Services representative on all other Added Choice issues. (Monday–Friday, 8 a.m.–5 p.m.; Saturday, 8 a.m.–noon)

When you have a question, ask us. Our Kaiser Permanente Member Services representatives can help you understand:

- Your benefits
- How to file an appeal for Kaiser Permanente services
- How to change your address on our records
- How to replace your Kaiser Permanente Added Choice ID card
- Professional qualifications of Kaiser Permanente primary and specialty practitioners

The following are also available upon request:

- Conditions under which Kaiser Permanente may change premium rates and the factors that may affect changes in the rates
- Provisions related to renewing your coverage
- The geographic area served

If you have questions about claims and billing, please call our Patient Financial Services Department at 808-432-5340 (Oahu) or toll free at 1-888-597-5340 (neighbor islands).

MEMBER SATISFACTION PROCEDURE

We welcome your comments and concerns. They are an encouragement when we meet your expectations and an opportunity for improvement when we fall short. You may share your comments and concerns with your personal Kaiser Permanente physician or to another member of your Kaiser Permanente health care team, such as a departmental supervisor or patient advocate. You may also use the “Let Us Hear From You” customer feedback forms found in all Kaiser Permanente facilities, or call or write to Member Services. We’ll respond within 30 days of receiving your comments or concerns.

OUR ADDRESS:
Kaiser Foundation Health Plan, Inc.
Member Services
Added Choice Plan
711 Kapiolani Blvd.
Honolulu, HI 96813

PHONE NUMBERS:
Oahu and neighbor islands..1-800-966-5955
TTY, toll free..................................................711
Monday–Friday, 8 a.m.–5 p.m.
Saturday, 8 a.m.–noon

ABOUT QUALITY CARE

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

The Kaiser Permanente Added Choice plan offers you the choice of doctors you want combined with the advantage of Kaiser Permanente care and services. For more details, you can refer to the Added Choice Physicians and Locations Directory, your group’s Benefits Summary, and your KPIC Certificate of Insurance.

With Added Choice, you and your family have the freedom to choose any of the following options each time you seek care:

- Kaiser Permanente’s full-service care delivery system
- Contracted providers in the community
- Any licensed non-contracted provider

UNDERSTANDING YOUR ADDED CHOICE BENEFITS

<table>
<thead>
<tr>
<th>Network of providers</th>
<th>The Kaiser Permanente provider option</th>
<th>The contracted provider option</th>
<th>The non-contracted provider option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You can see Kaiser Permanente Hawaii physicians at any one of our 22 facilities on Oahu, Maui, and Hawaii Island, and Kauai, and Kaiser Permanente contracted physicians on Kauai, Lanai, and Molokai. Most Kaiser Permanente locations offer primary care, lab, X-ray, and pharmacy services together in one place.</td>
<td>As of June 2016, you can see more than 2,230 Kaiser Permanente Insurance Company (KPIC) contracted providers and 162 contracted hospitals and care facilities in Hawaii.</td>
<td>You can see any other licensed provider anywhere in the world as long as it’s a covered service under your plan and a type of care available within the United States.</td>
</tr>
</tbody>
</table>

| Choosing a doctor | You choose your own primary care physician (practicing in internal medicine, pediatrics, or family medicine) to coordinate care and direct access to specialists. Women may also choose their own obstetrician-gynecologist. | You are not required to choose a primary care physician. | You are not required to choose a primary care physician. |

| Referrals | Your personal physician can refer you to a Kaiser Permanente specialist. | Referrals are not needed when seeking specialty care. Precertification is required for all inpatient admission and certain outpatient services. Failure to obtain precertification may result in a reduction in the benefits that would otherwise be payable. | Referrals are not needed when seeking specialty care. Precertification is required for all inpatient admission and certain outpatient services. Failure to obtain precertification may result in a reduction in the benefits that would otherwise be payable. |

1The contracted and non-contracted provider options of this plan are underwritten by KPIC, a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP).
## UNDERSTANDING YOUR ADDED CHOICE BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>The Kaiser Permanente provider option</th>
<th>The contracted provider option¹</th>
<th>The non-contracted provider option¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient prescription drugs</strong></td>
<td>Lowest out-of-pocket costs. You may have prescription orders mailed to your home for additional convenience and savings. Prescriptions written by contracted and non-contracted providers may be filled at any Kaiser Permanente pharmacy (subject to our drug formulary).</td>
<td>If your employer purchased coverage for outpatient prescription drugs, the out-of-pocket costs are generally higher than under the Kaiser Permanente provider option. You can visit any one of the contracted pharmacies in Hawaii for routine pharmacy services (subject to the KPIC drug formulary). Not all drug benefits are available at all contracted pharmacies.</td>
<td>No prescription drug coverage, except for FDA-approved contraceptives, oral chemotherapy drugs, and tobacco cessation drugs. You must pay the full cost of the drug and then file a claim with KPIC for reimbursement.</td>
</tr>
<tr>
<td><strong>Lifetime maximum</strong></td>
<td>Unlimited lifetime maximum.</td>
<td>No maximum benefit while insured.</td>
<td></td>
</tr>
<tr>
<td><strong>Annual deductibles</strong></td>
<td>No annual deductible.</td>
<td>Accumulation period (calendar or plan year) deductible applies.</td>
<td>Accumulation period (calendar or plan year) deductible applies.</td>
</tr>
<tr>
<td><strong>Out-of-pocket costs</strong></td>
<td>Lowest</td>
<td>Generally higher than under the Kaiser Permanente provider option.</td>
<td>Generally higher than under the Kaiser Permanente provider option.</td>
</tr>
<tr>
<td><strong>Claims</strong></td>
<td>Virtually no paperwork or claims to file.</td>
<td>Most contracted providers file claims on your behalf. You are responsible for meeting the annual deductible and any applicable coinsurance. When you see a contracted provider, the negotiated rate equals the MAC, protecting you from balance billing.</td>
<td>You will be required to file a claim for reimbursement. The provider will bill you for the balance of expenses not covered by the KPIC reimbursement. You are responsible for meeting the annual deductible, any applicable coinsurance, and the difference between the Maximum Allowable Charge and the actual billed charge.</td>
</tr>
<tr>
<td><strong>How much a $250 office visit for a covered expense would cost you²</strong></td>
<td>Total billed charge: $250 Your copayment: $20 Your total responsibility: $20</td>
<td><strong>After annual deductible is met:</strong> Total billed charge: $250 MAC: $180 You pay 20% of the MAC ($180 x 20%): $36 KPIC pays $144 ($180 x 80%). Your total responsibility: $36</td>
<td><strong>After annual deductible is met:</strong> Total billed charge: $250 MAC: $180 You pay 20% of the MAC ($180 x 20%): $36 You are also responsible for the difference between the billed charge and MAC ($250 - $180 = $70) KPIC pays $144 Your total responsibility: ($36 + $70): $106</td>
</tr>
</tbody>
</table>

²This example is an illustration of the type of out-of-pocket costs you may incur based on the type of provider you choose. Your actual plan benefits may vary from the example shown. Benefits under the Added Choice plan are also subject to exclusions and limitations.
# ADDED CHOICE GLOSSARY

## Balance Billing
Any charge above the KPIC determined Maximum Allowable Charge (MAC) billed to you by your non-contracted provider.

## Coinsurance
The percentage of covered charges you must pay for the care you receive. Coinsurance amounts apply toward satisfaction of your out-of-pocket maximum.

## Copayment
A specific dollar amount you must pay for covered health plan services. Copayments apply toward your Kaiser Permanente provider option out-of-pocket maximum.

## Deductible
The dollar amount of covered charges you must pay during each accumulation period before benefits become payable for covered services. Deductibles are applicable only for the contracted and non-contracted provider options. Deductibles apply toward satisfaction of your out-of-pocket maximum.

## Formulary
Our preferred drug list of generic, brand-name, and specialty drug medications that Kaiser Permanente physicians and pharmacists have determined to be the safest, most appropriate, and most cost-effective treatments for our members. Please note that KPIC has a separate formulary applicable to any prescription drug coverage provided under its tiers of coverage.

## Maximum Allowable Charge (MAC)
The maximum charge that we will consider for a covered service you receive from contracted or non-contracted health care providers. For nonemergency services, the MAC is determined by Kaiser Permanente Insurance Company (KPIC) as the lesser of: (1) the usual and customary charge for services or supplies generally made by providers within a local area; (2) the rate KPIC has negotiated in advance with the provider for covered services; or (3) the actual billed charges for the covered services. For non-contracted providers, this amount may be less than the amount billed by your provider. You may be responsible for any amount in excess of the MAC when seeking care from non-contracted providers. You can find a more detailed description of the MAC in your KPIC Certificate of Insurance. An exception to this definition exists for emergency services rendered by non-contracted providers. Please see your KPIC Certificate of Insurance for details regarding this exception.

## Precertification
The required assessment of the medical necessity, efficiency, and/or appropriateness of specified health care services or treatment made by the KPIC Medical Review Program. Requests for precertification must be made by the covered person or the covered person’s attending physician prior to the commencement of any service or treatment. If precertification is required, it must be obtained in order to avoid a reduction in the benefits otherwise payable. Consult your KPIC Certificate of Insurance for complete details. If you have questions, call us at 1-800-238-5742 and press 2 for precertification. TTY users may call 711.
UNLOCK THE DOOR TO GOOD HEALTH

Your Kaiser Permanente Added Choice identification (ID) card is your key to accessing the health care services you need. Please carry your ID card with you at all times. You’ll need to present your ID card along with a valid photo ID card every time you receive care. If you lose or damage your ID card, call Member Services at 1-800-966-5955, or log on to kp.org to request a new one.

Your new ID card, as well as any replacement card, will be mailed to you. New Kaiser Permanente members should carry a temporary ID card (found on the last page of the enrollment form) for at least 10 days or until the permanent one is mailed to you.

Here’s an example of what your ID card looks like.

Protecting you from health care fraud

Fraud and identity theft are growing problems everywhere. We take protecting you and your medical information seriously. One way we do this is by checking your Kaiser Permanente Added Choice ID card and a photo ID when you come in for care. We’re committed to ethical conduct, integrity in our work, and compliance with all regulatory requirements. We provide training and resources to help our employees and physicians protect your privacy and help prevent fraud and identity theft. We monitor our systems and operations to detect signs of misconduct and are committed to taking corrective action as needed.

If you see anyone using your information or our resources improperly, call Member Services at 1-800-966-5955. For more information about how we’re working to protect you, visit kp.org/protectingyou.
MAKE YOUR CARE PERSONAL

One of the most important decisions you’ll make as a member is choosing your own personal physician. Your doctor is your health care advocate and your direct link to all Kaiser Permanente facilities, including referrals to specialists. Your personal physician will work with you to help you meet your health goals so that you can live well.

You can maximize covered benefits through your choice of providers. As an Added Choice member, you may choose Kaiser Permanente providers, contracted providers, or non-contracted providers. In most cases, receiving care from Kaiser Permanente providers means that you’ll receive the highest level of coverage from your Added Choice plan and will likely pay the lowest level of out-of-pocket costs. Your medical care within Kaiser Permanente is the responsibility of the Hawaii Permanente Medical Group, Inc., a corporation of more than 500 physicians.

HOW TO CHOOSE YOUR DOCTOR AT KAISER PERMANENTE

You may select your Kaiser Permanente personal physician from any of our available providers. You can also change your Kaiser Permanente personal physician at any time and for any reason. When you make a selection, it is effective immediately.

Step 1: Select the Kaiser Permanente medical facility where you plan to receive the majority of services. Most members select a location that is convenient to their home or work.

Step 2: Decide what kind of doctor is best for you and each family member. You may choose a doctor from one of the three primary care specialties. Please note that some locations don’t have all three primary care specialties.

• Family Medicine cares for members of all ages and specializes in caring for entire families.
• Internal Medicine specializes in medical and preventive care for adults.
• Pediatrics focuses on the specialized needs of children from birth to the age of 21.

Step 3: Review the profiles of the available physicians. You have several resources to choose from:

• Physician biography cards, which provide background information on each facility’s physicians. You can find these cards at reception counters in our medical facilities.
• Our Added Choice Physicians and Locations Directory.
• Our website, kp.org/choosetheyourdoctor.

Step 4: Call your medical facility and notify the receptionist of your preferred physician.

For more information on how to select or change your Kaiser Permanente personal physician, please contact Member Services at 1-800-966-5955.
APPPOINTMENTS

Services offered by our medical facilities are listed in the *Added Choice Physicians and Locations Directory* and online in our facility directory at [kp.org](http://kp.org). Call the appointment number at your medical facility during office hours for nonemergency health problems or for routine examinations. Please let us know the reason for your visit when you call to schedule your appointment.

For easier scheduling, please have your Kaiser Permanente Added Choice ID card ready. You’ll also need to present this ID card, along with a valid photo ID, when you check in. Be prepared to give the appointment clerk your medical record number (located just above your name on your Kaiser Permanente Added Choice ID card), your personal physician’s name, and your medical history so we can better direct your care. Please be ready to provide information about any other health plan coverage you may have. Bring your other health plan ID cards and present them with your Kaiser Permanente ID card and photo ID. You may also ask to speak to an advice nurse at any time for health information.

If you need to cancel or reschedule an appointment, call the 24-hour appointment cancellation line of your Kaiser Permanente facility so we can offer this time to other members who may need it.

If you’re bringing a child in for treatment and the child is not your own, you must have an *Appointment of Representatives Authorized to Consent to Treatment of a Minor* form, which a parent needs to sign in the presence of a Kaiser Permanente staff member. To obtain this form, please contact Member Services at 1-800-966-5955. You can also bring a notarized *Health Care Power of Attorney* form. We will not be able to treat the child without one of these forms.

SELF-REFERRALS AND SPECIALISTS

At Kaiser Permanente, you don’t need a referral to make appointments for the following in-network services:

- Alcohol and drug treatment
- Behavioral health services
- Eye examinations for glasses and contact lenses
- Family practice
- Health education
- Internal medicine
- Medication counseling
- Obstetrics-gynecology
- Occupational health services
- Pediatrics
- Physical therapy
- Social work
- Sports medicine
- Tobacco telephone counseling
- Travel medicine

You’ll need a referral to see a Kaiser Permanente provider for services not listed above. Your Kaiser Permanente personal physician can refer you to a specialist when it’s medically necessary.

TRANSPORTATION SERVICES

We provide free shuttle service on Oahu between our Moanalua Medical Center and the following facilities:

- Honolulu Medical Office
- Kahuku Clinic
- Kapolei Clinic
- Koolau Medical Office
- Mapunapuna Medical Office
- Nanaikeola Clinic
- Waipio Medical Office
- Honolulu International Airport Interisland Terminal

Shuttle operates Monday–Friday, except holidays. Schedules and sign-ups are posted at each location. You can find the shuttle schedule at [kp.org/locations](http://kp.org/locations).
NEIGHBOR ISLAND CONCIERGE

Your doctor will refer you to a specialist when it’s medically necessary. In some cases, that may mean recommending our neighbor island members get treated on Oahu, where you’ll be cared for by a team of physicians who have access to facilities and equipment that may not be available on your island. If you have to go to Oahu for medically necessary care, we can assist you with coordinating your medical appointments. Our concierge can also offer shuttle and ground transportation information, hotel and housing recommendations, along with tips on making the most of your stay.

808-432-UFLY (808-432-8359)
Monday–Friday, 7:30 a.m.–4 p.m.

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

Maui..............................................808-243-6589
Kauai, Molokai, Lanai, and Hawaii Island ..............1-800-214-6572
Monday–Friday, 8 a.m.–5 p.m.
Saturday, 8 a.m.–noon (emergencies only)
Closed Sunday and most holidays

KAISER PERMANENTE AFTER-HOURS NURSE ADVICE LINE

If you have medical concerns after our facilities have closed, call our After-Hours Nurse Advice Line for medical advice. You will need to provide the medical record number of the person for whom you are calling.

The After-Hours Nurse Advice Line is open:
• Monday–Friday, 5 p.m.–8 a.m. (next day)
• Weekends and holidays, 24 hours

Oahu............................................808-432-7700
Neighbor islands .................1-800-467-3011
TTY ..................................................711 (toll free)
for the hearing/speech impaired

KAISER PERMANENTE AFTER-HOURS CARE

We provide extended, non-emergency, non-routine care after our facilities are closed.

At our Moanalua Medical Center on Oahu, after-hours care is available:
• Monday–Friday, 5–10 p.m.
• Weekends and holidays, 8 a.m.–10 p.m.

Please call 808-432-7700 to make an appointment before your visit. You can park in the Moanalua Medical Center garage and use the main entrance to the hospital (go to the first-floor cashier). The cost for an after-hours visit is the same as a routine doctor’s appointment.

At our Maui Lani Medical Office on Maui, after-hours care is available:
• Monday–Friday, 5–8 p.m.
• Weekends and most holidays, 8 a.m.–5 p.m.
• Closed Christmas and New Year’s Day

Please call 808-243-6050 to make an appointment before your visit. The cost for an after-hours visit is the same as a routine doctor’s appointment.
URGENT CARE

ON HAWAII ISLAND
There are several urgent care centers on Hawaii Island that have contracted with Kaiser Permanente and KPIC. Your regular office copayment will be collected at the time of service. If, upon review, your medical need is considered not urgent, then your claim will be processed subject to the Added Choice accumulation period (calendar or plan year) deductible and coinsurance.

Hilo Urgent Care Center
45 Mohouli St.
(across from Kapiolani School playground)
Mon.–Fri., 8:30 a.m.–8:30 p.m.
Sat.–Sun., 8:30 a.m.–4:30 p.m.
808-969-3051

Urgent Care Keaau
16-590 Old Volcano Rd.
Mon.–Fri., 8:30 a.m.–6:30 p.m.
Sat.–Sun., 8:30 a.m.–4:30 p.m.
808-966-7942

Aloha Kona Urgent Care
75-5995 Kuakini Hwy., #213
Open every day, 1–9 p.m.
808-365-2297

Pahoa Family Health Center
15-2866 Pahoa Village Rd., Bldg. C
Mon.–Fri., 7 a.m.–6 p.m.
1st Thur. of month, 9 a.m.–6 p.m.
3rd Thurs. of month, 8 a.m.–6 p.m.
808-965-9711

Hilo Family Health Center
1178 Kinoole Street, Bldg. B
Mon.–Fri., 7 a.m.–6 p.m.
1st Thurs. of month, 9 a.m.–6 p.m.
3rd Thurs. of month, 8 a.m.–6 p.m.
808-969-1427

Keauhou Urgent Care Center
Keauhou Shopping Center (across from theater)
78-6831 Alii Dr., #418
Open every day, 9 a.m.–7 p.m.
808-322-2544

Ka‘u Family Health
95-5583 Mamalahoa Hwy.
Mon.–Fri., 8 a.m.–5:30 p.m.
3rd Thurs. of month, 9 a.m.–5:30 p.m.
808-929-7311

If the urgent care physician gives you a prescription, your options are to fill it:

• At a Kaiser Permanente pharmacy, if the urgent care physician says you can wait for the facility to reopen to fill your prescription and start your medication.

• At a retail pharmacy in the community. You will need to pay the full price for the medication and file a claim with Kaiser Permanente by sending your name, medical record number, paid receipts, and medical documentation to the following address within 90 days (or as soon as reasonably possible) after you received the care. Please note that if, upon review, your medical need is considered not urgent, we will be unable to reimburse you for the medication.

Kaiser Foundation Health Plan, Inc.
Attn: National Claims – Hawaii Region
P.O. Box 378021
Denver, CO 80237

ON MAUI
For urgent care in East Maui, Hana Health has contracted with Kaiser Permanente and KPIC. Your regular office copayment will be collected at the time of service. If, upon review, your medical need is considered not urgent, then your claim will be processed as an out-of-network claim subject to the Added Choice accumulation period (calendar or plan year) deductible and any applicable coinsurance.

• Hana Health
4590 Hana Hwy.
Mon., Tues., Wed., Fri., 8 a.m.–5 p.m.
Thurs., 8 a.m.–noon and 2–8 p.m.
Sat., 8 a.m.–noon
808-248-8294
USING YOUR IN-NETWORK BENEFITS AT KAISER PERMANENTE

ON KAUAII
For urgent care on Kauai, Kauai Urgent Care has contracted with Kaiser Permanente and KPIC. Your regular office copayment will be collected at the time of service. If, upon review, your medical need is considered not urgent, then your claim will be processed as an out-of-network claim subject to the Added Choice accumulation period (calendar or plan year) deductible and any applicable coinsurance.

• Kauai Urgent Care
  4484 Pahee St.
  Open every day, 8 a.m.–7 p.m.
  808-245-1532

If the urgent care physician gives you a prescription, your options are to fill it:

• At a Kaiser Permanente pharmacy, if the urgent care physician says you can wait for the facility to reopen.

• At a retail pharmacy in the community. You will need to pay the full price for the medication and file a claim with Kaiser Permanente by sending your name, medical record number, paid receipts, and medical documentation to the address below within 90 days (or as soon as reasonably possible) after you received the care. Please note that if, upon review, your medical need is considered not urgent, we will be unable to reimburse you for the medication.

Kaiser Foundation Health Plan, Inc.
Attn: National Claims – Hawaii Region
P.O. Box 378021
Denver, CO 80237

EMERGENCY CARE
We cover initial urgent and emergency care anywhere in the world. If you think you’re experiencing an emergency, go immediately to an emergency department. If you think you need an ambulance, call 911. Ambulance services will be paid according to your plan benefits if it is determined to be medically necessary.

Emergency medical conditions need immediate medical attention to avoid serious threats to your body and health. We define an "emergency medical condition" as an illness or injury that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

➤ Placing the person’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy

➤ Serious impairment to bodily functions

➤ Serious dysfunction of any bodily organ or part

Examples of an emergency medical condition include but are not limited to:

• Severe pain
• Suspected heart attack or stroke
• Extreme difficulty breathing
• Bleeding that will not stop
• Major burns
• Seizures
• Sudden onset of severe headache
• Suspected poisoning
USING YOUR IN-NETWORK BENEFITS
AT KAISER PERMANENTE

We cover emergency medical services at the in-network benefit level according to your plan terms. If admitted to a non-Kaiser Permanente facility, you or a family member must notify us within 48 hours after care begins (or as soon as reasonably possible) by calling the phone number on the back of your Kaiser Permanente member ID card or your claim for payment may be denied.

If you need continuing or follow-up care, you’ll need to receive that care at Kaiser Permanente or the care will be considered out-of-network care and subject to the out-of-network benefit level and the associated cost-sharing requirements.

Nonemergency medical services received in an emergency care setting that are not covered by Kaiser Permanente at the in-network benefit level may be eligible for coverage by KPIC at the out-of-network benefit level.

Refer to your Benefits Summary or Group Medical and Hospital Service Agreement and KPIC Certificate of Insurance, which you may obtain from your employer or group administrator, for a full description of your coverage for emergency and urgent care services.
UTILIZATION MANAGEMENT FOR EMERGENCY SERVICES

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

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

If, at any time, you feel you are not receiving coverage for an item or service that you believe is medically necessary, you have the right to make a request for services or supplies you have not received, or to file a claim for payment of charges you’ve incurred. If you don’t agree with our decision regarding your request, you have the right to request an appeal. To file an appeal, follow the directions on page 34.

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

For any UM inquiries during regular business hours, please call Member Services:

**1-800-966-5955**
711 (TTY for the hearing/speech impaired)
Monday–Friday, 8 a.m.–5 p.m.
Saturday, 8 a.m.–noon

Language assistance services are provided free of charge for members through an interpreter. Bilingual Access Line: **808-526-9724**

After regular business hours and holidays
**808-432-7100** (Oahu)
**1-800-227-0482** (neighbor islands)

After regular business hours, your message will be forwarded to our UM team and your call will be returned the next business day. You may also fax us at **808-432-7419**.
HOSPITAL SERVICES
The Moanalua Medical Center is a full-service healing hospital. Patients and families are at the center of everything we do. Specially trained clinicians and caregivers partner to provide compassionate and quality care and services. Admission is based on a physician review of your medical condition. Services include medical, surgical, perinatal, labor and delivery, neonatal, pediatric, and intensive care for acute illness and injury. Our hospital also includes an ambulatory treatment center, a clinical decision unit for observation stays, operating rooms, and emergency services.

On the neighbor islands, our physicians will direct you to a Kaiser Permanente–designated hospital on your island. This may include:
• Maui Memorial Medical Center
• Kona Community Hospital
• Hilo Medical Center
• North Hawaii Community Hospital
• Wilcox Memorial Hospital
• West Kauai Medical Center
• Samuel Mahelona Memorial Hospital
• Molokai General Hospital
• Lanai Community Hospital

The need to admit or transfer you to the Moanalua Medical Center will be determined by your physician.

GETTING CARE ON KAUA‘I, LANAI, AND MOLOKAI
On the islands of Kauai, Lanai, and Molokai, we have contracted with independent primary care providers to provide care for our members. You can choose your own personal physician and go to him or her directly for all your primary care needs as well as the management of your care, including coordination of specialty care and referrals. For a list of services and departments you can see without a referral, please review the self-referrals and specialists section on page 11. An authorized referral is required for specialty care. Your personal physician is your partner to coordinate your overall medical care.

A listing of primary and specialty care physicians can be found in the Added Choice Physicians and Locations Directory. You can also call our Member Services at 1-800-966-5955 or our toll-free TTY number at 711 for the hearing/speech impaired, Monday–Friday from 8 a.m.–5 p.m. and Saturday from 8 a.m.–noon. Or you can visit our website at kp.org.
PAYING FOR YOUR VISIT

Once you’ve registered with our Kaiser Permanente clinic receptionist, we will collect your office visit copayment then direct you to your provider.

When you plan for your visit, please remember that all supplemental charges, such as office visit, lab, X-ray, other test, procedure, or prescription medication copayments, are due the same day you receive services. You may pay with cash, debit card, personal check, or credit card, including Visa®, MasterCard®, Discover®, and American Express®.

You may be billed additional supplemental charges for services performed after you’ve paid and left the clinic. For example, your doctor may need to send tissue samples or specimens for further testing. These additional services, which are based on initial test results, are performed to help your doctor provide you with high-quality care.

We may request deposits prior to your appointment for certain high-cost services or items related to procedures you’ve been scheduled for. We may also require payment in advance for services not covered under your health plan benefits. You’ll be notified in advance when we require deposits or prepayments.

If you have questions about billing, please call our Patient Financial Services Department at 808-432-5340 (Oahu) or toll free at 1-888-597-5340 (neighbor islands).

LIMIT ON SUPPLEMENTAL CHARGES

The amount of supplemental charges for “Basic Health Services” paid by a member (or family unit) in an accumulation period (calendar or plan year) is limited for each type of Kaiser Permanente plan.

Please see your Benefits Summary or contact Kaiser Permanente Member Services at 1-800-966-5955 or toll free at 711 (TTY) for more information.
PHARMACY SERVICES

Pharmacies are located in most of our Kaiser Permanente facilities and are open during regular business hours. You can get prescriptions filled and buy over-the-counter medications and supplies at our Kaiser Permanente pharmacies. Also, if you receive a prescription from a contracted or non-contracted physician, you may get it filled at one of the designated contracted pharmacies. A list of the pharmacies that are available to you can be found in the Added Choice Physicians and Locations Directory.

Not all plans have coverage for prescription drugs. Please consult your Benefits Summary or Group Medical and Hospital Service Agreement and KPIC Certificate of Insurance for more information about your coverage. If you have a prescription drug benefit, present your Kaiser Permanente Added Choice ID card when filling your prescriptions.

COVERED DRUGS
We use an approved list of drugs to make sure that the most appropriate, safe, and effective prescription medications are available to you. This list is reviewed on a regular basis and includes generic, brand name, and specialty drugs covered under the prescription drug benefit.

DRUGS NOT COVERED
• Nonprescription or over-the-counter medicines (some exceptions apply)
• Drugs for cosmetic uses
• Drugs used for reasons not approved by the FDA
• Plan-excluded prescription drugs

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

PRESCRIPTION ORDERS*
Save time by ordering refills using My Health Manager at kp.org. Get a 90-day supply of qualified drugs for the cost of a 60-day supply by using our convenient mail-order service. We pay the postage.

You can refill your prescriptions written by a Kaiser Permanente doctor, when you’ve used two-thirds of your existing supply, using one of the methods below.

• For the quickest turnaround time, order online at kp.org/pharmacycenter.

• Order via Kaiser Permanente Hawaii’s automated prescription refill service by calling 808-643-RxRx (808-643-7979). You’ll have the following options:
  - To check your order status, press 1.
  - To order refills, press 2. You will be asked to enter your medical record number and prescription number. Then press 1 to receive your refill via mail order.
  - To listen to detailed instructions, press 3.

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

* Mail-order service is only available for prescriptions filled at a Kaiser Permanente pharmacy. We are not licensed to mail medications out of state. There are restrictions for delivery of certain medications and supplies, including but not limited to controlled medications, injections, medications affected by temperature, and medications excluded by Kaiser Permanente’s Pharmacy & Therapeutics Committee.
**Q:** What is the advantage of using Kaiser Permanente’s mail-order pharmacy service?

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

**Q:** My drug is on the Kaiser Permanente Hawaii drug formulary. What are my options?

**A:** If your drug is on the Kaiser Permanente formulary, you have the following options:

- Fill your prescription at any Kaiser Permanente pharmacy and pay the applicable copay
- Use our Kaiser Permanente mail order service to get a 90-day supply for the same price as a 60-day supply for most medications
- Fill your prescription at any Added Choice contracted pharmacy and pay the applicable coinsurance. The out-of-pocket costs are generally higher than when you fill your prescriptions at a Kaiser Permanente pharmacy.

**Q:** My drug is not on the Kaiser Permanente Hawaii drug formulary. What are my options?

**A:** If your drug is not on the Kaiser Permanente formulary, you have the following options:

- If your Kaiser Permanente physician determines that a non-formulary medication is medically necessary for your care, the drug will be covered at a Kaiser Permanente pharmacy at your applicable copay. Otherwise, you must pay full price for the drug at any Kaiser Permanente pharmacy.
- If a drug is prescribed by an Added Choice contracted or non-contracted physician and brought into a Kaiser Permanente pharmacy, our pharmacists will contact your doctor for an alternative drug that is on our drug formulary. If your doctor agrees to switch to the formulary alternative, we will do so and inform you. If your doctor deems the non-formulary drug medically necessary, then the drug will be covered at a Kaiser Permanente pharmacy at your applicable copay.
- Fill your prescription at any Added Choice contracted pharmacy and pay the applicable coinsurance.

**Q:** How can my non-Kaiser Permanente doctor or I find out if my drug is on the Kaiser Permanente in-network or KPIC drug formularies?

**A:** You or your non-Kaiser Permanente doctor have the following options:

- Our Kaiser Permanente Hawaii drug formulary can be found at kp.org/formulary. You or your doctor may also contact Member Services at 1-800-966-5955, weekdays, 8 a.m.–5 p.m. and Saturdays, 8 a.m.–noon, and we can check the formulary for you.
- Our KPIC drug formulary can be found at info.kaiserpermanente.org/html/kpic-hawaii/drugformulary.html You or your doctor may also contact the Added Choice Helpline at 1-800-238-5742 weekdays, 8 a.m.–5 p.m. and Saturdays, 8 a.m.–noon.

**Formulary Definition:** Our preferred drug list of generic, brand-name, and specialty drug medications that Kaiser Permanente physicians and pharmacists have determined to be the safest, most appropriate, and most cost-effective treatments for our members. Please note that KPIC has a separate formulary applicable to any prescription drug coverage provided under its tiers of coverage.

* Kaiser Permanente drug coverage is required to use the mail-order service. We are not licensed to mail medicine out of state. There are restrictions for delivery of certain medications and supplies, including but not limited to controlled medications, injections, medications affected by temperature, and medications excluded by Kaiser Permanente’s Pharmacy & Therapeutics Committee.
CONTRACTED PROVIDERS

As an Added Choice member, you have the freedom to receive medical services from Kaiser Permanente providers, contracted providers, and non-contracted providers. Be sure to check if your provider is a contracted provider prior to receiving services. Contracted providers have agreed to negotiated rates for covered services and have agreed not to collect from you amounts over the MAC.

A listing of contracted providers is found in the Added Choice Physicians and Locations Directory. If you have questions about whether your provider is contracted with Kaiser Permanente, contact Member Services on Oahu at 1-800-966-5955.

NON-CONTRACTED PROVIDERS

Non-contracted providers have not agreed to negotiated rates with Kaiser Permanente. If you have chosen a non-contracted provider, you may be billed an amount above the MAC and your non-contracted provider may ask you to pay in full at the time services are provided. You can find an explanation of the MAC and how your costs may vary with contracted and non-contracted providers on pages 6 and 7 of this handbook.

OUT-OF-POCKET BENEFIT MAXIMUMS

For an individual: When your share of covered charges incurred equals the out-of-pocket maximum (shown in the KPIC Certificate of Insurance) during an accumulation period (calendar or plan year), the percentage payable will increase to 100 percent of further covered charges incurred by you during the remainder of that accumulation period.

For a family: When the amount of covered charges incurred by all covered family members equals the out-of-pocket maximum (shown in the KPIC Certificate of Insurance) during an accumulation period, the percentage payable will increase to 100 percent of further covered charges incurred by covered family members during the remainder of that accumulation period.

Any part of a charge that does not qualify as a covered charge will not be applied toward satisfaction of the accumulation period deductible or the out-of-pocket maximum.

APPOINTMENTS

You may make appointments for covered services with contracted and non-contracted providers by calling the provider’s office directly. Consult your KPIC Certificate of Insurance for a complete listing of covered services, exclusions, and limitations before you receive care from a contracted or non-contracted provider. Before receiving treatment, be sure to confirm:

- Your provider’s status in the Added Choice plan. Providers may be added or deleted from the Added Choice plan without notice to you.
- If the services require precertification. In most cases, you may go directly to a contracted or non-contracted provider, but in a few circumstances, you must obtain precertification by the KPIC Medical Review Program before receiving treatment. Consult your Certificate of Insurance for complete details regarding precertification.

To receive nonemergency services from contracted and non-contracted providers, just follow these easy steps:

- Present your Kaiser Permanente Added Choice ID card when you check in.
- Provide your medical record number and correct mailing address.
- Have your provider file a standard CMS-1500 claim form.

See how to file a claim at “Filing a nonemergency care claim for payment” on page 40. Any applicable deductibles must be paid per member/family before benefits may become payable.
PRECERTIFICATION OF SERVICES

Precertification is required prior to receiving the following nonemergency services by contracted and non-contracted providers:

- All inpatient admissions, including residential treatment and skilled nursing facility admissions
- Outpatient surgery (performed at a hospital, ambulatory surgery center or other licensed facility)
- Outpatient procedures (limited to hyperbaric oxygen, enhanced external counterpulsation (EECP), plasmapharesis for multiple sclerosis, anodyne therapy, pill endoscopy, radiofrequency ablation, sclerotherapy, stab phlebectomy, uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP, sleep studies, vagal nerve stimulation, resection, hemispherectomy, corpus colostomy surgery, implants)
- Applied Behavior Analysis
- Outpatient rehabilitation (physical therapy, speech therapy, occupational therapy)
- Reconstruction surgery
- Pain management services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections)
- Upper airway procedures
- Nonemergent (scheduled) air or ground ambulance transport
- Genetic testing
- Orthotics/prosthetics
- Implantable prosthetics
- Home health and home infusion services
- Infertility procedures
- Outpatient injectable drugs
- Durable medical equipment
- Temporomandibular joint disorders (TMJ)/orthognathic surgery
- Radiation therapy services
- Clinical trials
- Imaging service: magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), positron emission tomography (PET), electronic beam computed tomography (EBCT), single-photon emission computerized tomography (SPECT)

To receive maximum coverage for services from a contracted or non-contracted provider, you must call the Added Choice Helpline at 1-800-238-5742 (press 2 for precertification) at least three business days prior to receiving these services. When you call, you’ll be asked for:

- Your name and medical record number (found on your Kaiser Permanente Added Choice ID card)
- Your provider’s name, address, and phone number
- The procedure the provider has recommended
- The hospital name, if appropriate

Contact your provider for specific information about the care you’ll be receiving. You and your provider will receive a letter from the KPIC Medical Review Program, which states that the procedure has been determined to be medically necessary. If the procedure has not been determined to be medically necessary, the KPIC Medical Review Program will contact you and your provider by phone. To file an appeal, follow the directions on page 34.
KEEPING YOU HEALTHY

CONNECTING YOU WITH OUR FAMILY OF SELF-CARE TOOLS

At Kaiser Permanente, helping members like you get and stay healthy is one of our highest priorities.

Using our website, you can access the latest healthy lifestyle and medical information right from your own home — anytime, day or night. From our online health and drug encyclopedias to programs that can help you manage and improve your health, you’ll find the resources you need at kp.org.

Whether you’d like to quit smoking, lose weight, control your cholesterol, start a fitness program, manage your diabetes, or reduce stress, we’re here to help.

We understand that making lifestyle changes isn’t easy. That’s why we offer a broad range of self-care tools designed to help you succeed — one step at a time. We encourage you to use these tools at your convenience. (We regret that certain “secure features” of our online tools are not currently available for members living on Kauai, Molokai, or Lanai. These members may not be able to email physicians and see lab results but they can access kp.org, including the Total Health Assessment and online Healthy Lifestyle Programs.)

MY HEALTH MANAGER ON KP.ORG

Linked directly to your medical record, My Health Manager gives you the power to manage your health online at kp.org. You can email your doctor’s office, order prescription refills, view most lab test results, request routine appointments, check past office visit information, look up future appointments, and more. These free, time-saving features can help you spend less time managing your health and more time enjoying it.

To use the secure features of My Health Manager, start by going to kp.org/registernow. Once you register, you can sign on to kp.org with your user ID and password. Registration is quick and easy — you’ll be able to get connected in a single visit, without having to wait for your password to be emailed to you.

CONNECT TO BETTER HEALTH ONLINE WITH JOHNSON & JOHNSON HEALTH AND WELLNESS SOLUTIONS OUTCOMES

Kaiser Permanente Hawaii offers you many ways to improve your lifestyle with customized online programs designed to help you live well and thrive. These programs are brought to you in collaboration with Johnson & Johnson Health and Wellness Solutions Outcomes, and we offer them only to our members. To get started and choose a program, visit kp.org/healthylifestyles.
CHOOSEHEALTHY™

As a Kaiser Permanente Hawaii member, you have access to discounts on health products and services through ChooseHealthy. ChooseHealthy is a comprehensive health website offering a directory of complementary health care providers, information about complementary health care services, and discounts on health and wellness products such as:

- Acupuncture
- Massage therapy services
- Fitness club memberships
- Chiropractic care
- Herbs, vitamins, and supplements
- Health and fitness books and videos

Through ChooseHealthy, you also have access to a new online feature called FitnessCoach®. This convenient resource offers personalized meal and exercise plans, telephone coaching on various health topics, and an array of tools such as online trackers that make it easy to monitor your progress on your computer.

You can use any contracted provider from ChooseHealthy, and no referral from your personal physician is required. You’re responsible for paying the contracted provider’s discounted fees at the time you receive care.

Visit kp.org/choosehealthy to learn more about this program, sign up, or take an online tour. Once you’ve joined, you’ll be able to search for complementary health information, shop for health products at the online store, or locate a complementary health care provider.

You can also call toll free 1-877-335-2746 to request a list of contracted providers, a member brochure, a product listing, or other information about ChooseHealthy. ChooseHealthy is a product of American Specialty Health, Incorporated.

PREVENTIVE CARE GUIDELINES

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

As your health care partner, we’ll do our part by focusing on early detection and timely treatment of disease. To monitor your health and identify symptoms at an early stage, we ask that you follow these preventive care guidelines. The services listed can be obtained through your health care team.

The preventive care guidelines on pages 26 to 29 are for healthy adults and children with no symptoms of illness. Your doctor may recommend that you have some of these tests more often based on the information you provide, including your age, medical history, and lifestyle. Children need frequent health examinations to have their growth and development monitored and to receive immunizations. Preventive care schedules often incorporate these aspects into each visit. The schedules allow for some variation.
## PREVENTIVE CARE GUIDELINES FOR CHILDREN AND ADOLESCENTS

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccination or screening test*</th>
<th>Checkup</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INFLUENZA ANNUALLY FROM AGE 6 MONTHS THROUGH LIFE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth</td>
<td>Hep B (hepatitis B)</td>
<td></td>
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<tr>
<td>2 weeks</td>
<td>Well child visit</td>
<td></td>
</tr>
<tr>
<td>2 months</td>
<td>DTaP (diphtheria/tetanus/acellular pertussis), Hib (Haemophilus influenzae type B), 2nd Hep B, polio vaccine, PCV (pneumococcal conjugate vaccine), 1st rotavirus oral vaccine</td>
<td>Well-child visit</td>
</tr>
<tr>
<td>4 months</td>
<td>2nd DTaP, 2nd Hib, 2nd polio vaccine, 2nd PCV, 2nd rotavirus oral vaccine</td>
<td>Well-child visit</td>
</tr>
<tr>
<td>6 months</td>
<td>3rd DTaP, 3rd Hib, 3rd Hep B, 3rd polio vaccine, 3rd PCV, influenza annually to age 18, 3rd rotavirus oral vaccine (if needed)</td>
<td>Well-child visit</td>
</tr>
<tr>
<td>9 months</td>
<td>Complete blood count, TB (tuberculosis) skin test if high risk</td>
<td>Well-child visit</td>
</tr>
<tr>
<td>12-13 months</td>
<td>1st MMR (measles/mumps/rubella), 1st Hep A (hepatitis A), 1st varicella (chickenpox)</td>
<td>Well-child visit</td>
</tr>
<tr>
<td>15 months</td>
<td>4th DTaP, Hib, PCV and polio at age 15 to 18 months</td>
<td>Well-child visit (when indicated)</td>
</tr>
<tr>
<td>18 months</td>
<td>2nd Hep A, 4th DTaP, Hib, PCV and polio if not completed at 15 months</td>
<td>Well-child visit</td>
</tr>
<tr>
<td>2-6 years</td>
<td>TB skin test once between ages 4-6 years, 2nd MMR, 2nd varicella (chickenpox), booster DTap, booster polio</td>
<td>Every year</td>
</tr>
<tr>
<td>7-13 years</td>
<td>Tdap (tetanus/diphtheria/acellular pertussis) at ages 11-12 years; 1st MCV4 (meningococcal conjugate vaccine) at ages 11-12 years; HPV (human papillomavirus) vaccine for females and males ages 11-26 years; diabetes and lipid screening for high-risk individuals</td>
<td>Every other year</td>
</tr>
<tr>
<td>7-21 years</td>
<td>Tdap if not given at 11-13 years (pregnant women require an extra dose of Tdap to protect their infant), then Td (tetanus/diphtheria) every 10 years; 2nd MCV4 at ages 16-18 years, annual chlamydia test for females if ever sexually active; complete blood count for females (once); diabetes and cholesterol screening for high-risk individuals</td>
<td>Every year, Physical Exam every other year.</td>
</tr>
</tbody>
</table>

*Vaccine and screening schedule subject to change. These are recommended preventive care guidelines that are subject to change based on the most current evidence and may not reflect covered benefits.
### KEEPING YOU HEALTHY

### SELF-CARE AND RISK COUNSELING FOR ALL AGES

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

### New medical technologies

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

### PREVENTIVE CARE GUIDELINES FOR ADULTS

<table>
<thead>
<tr>
<th>Action</th>
<th>Age</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VACCINATIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (flu)</td>
<td>18 years and older</td>
<td>Once every year</td>
</tr>
<tr>
<td>Zoster (shingles)</td>
<td>60 years and older</td>
<td>Once</td>
</tr>
<tr>
<td>Td (tetanus/diphtheria)</td>
<td>18 years and older</td>
<td>Once every 10 years</td>
</tr>
<tr>
<td>Tdap (tetanus/diphtheria/acellular pertussis)</td>
<td>18 years and older</td>
<td>Once in place of Td. Pregnant women require an extra dose of Tdap with each pregnancy to protect their infant.</td>
</tr>
<tr>
<td>Pneumococcus (pneumonia)</td>
<td>19-64 years</td>
<td>If high-risk conditions, such as diabetes, asthma, smoking, etc., exist</td>
</tr>
<tr>
<td></td>
<td>65 years and older</td>
<td>Once, regardless of risk factors (PCB, PPSV23)</td>
</tr>
<tr>
<td>HPV (human papillomavirus) vaccine series for females and males who have not been previously vaccinated</td>
<td>18-26 years</td>
<td>One series of 3 injections</td>
</tr>
<tr>
<td><strong>CANCER RISK SCREENINGS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iFOBT (stool blood test for colorectal cancer screen) OR Optional colonoscopy (speak to your doctor)</td>
<td>50-75 years</td>
<td>Once a year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Every 10 years</td>
</tr>
<tr>
<td>Mammogram</td>
<td>40-49 years</td>
<td>Consider after discussion with PCP</td>
</tr>
<tr>
<td></td>
<td>50-75 years</td>
<td>Every 1-2 years</td>
</tr>
<tr>
<td>Pap test</td>
<td>21-65 years</td>
<td>For ages 21-29, every 3 years; for ages 30-65, every 5 years with HPV co-testing or more frequently if high risk</td>
</tr>
</tbody>
</table>
Keeping you healthy

Preventive Care Guidelines for Adults

<table>
<thead>
<tr>
<th>Action</th>
<th>Age</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>18 years and older</td>
<td>Every 2 years</td>
</tr>
<tr>
<td>Lipid evaluation</td>
<td>Men and women age 18</td>
<td>Once if never done before</td>
</tr>
<tr>
<td></td>
<td>Men from 35 years</td>
<td>Every 5 years or more frequently for</td>
</tr>
<tr>
<td></td>
<td>Women from 45 years</td>
<td>higher-risk individuals</td>
</tr>
<tr>
<td>Bone mineral density test for</td>
<td>65 years</td>
<td>Once</td>
</tr>
<tr>
<td>osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sexually Transmitted Diseases</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia test</td>
<td>18-25 years</td>
<td>Once a year for sexually active women and if</td>
</tr>
<tr>
<td></td>
<td></td>
<td>high risk.</td>
</tr>
</tbody>
</table>

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

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

Coverage After a Mastectomy

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

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

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

Learn more about breast cancer online at kp.org/breastcancer.
Kaiser Permanente Added Choice Member Handbook

KAISER ON-THE-JOB® OCCUPATIONAL HEALTH SERVICES

Occupational Health Services focuses on keeping Hawaii’s employees healthy and working. Work-related injury care, employment physicals, commercial driver’s license examinations, and employer-requested substance abuse testing are a few of the services available to our members and nonmembers as well. These services are not covered under your benefit plan.

If you experience a work-related injury, call and ask for an appointment with Occupational Health Services. Our Occupational Health Services clinics are located on Oahu, Maui, and Hawaii Island. We offer medical care for work-related illnesses and injuries, and a variety of prevention and safety services geared to the workplace.

We have clinics with specially trained occupational health physicians and staff. Our administrative staff is available to assist you with all the paperwork associated with workers’ compensation claims.

After-hours or urgent care is available at the Moanalua Medical Center and Maui Lani Medical Office. Please check the scheduled hours at these facilities. Our Moanalua Medical Center’s Emergency Department provides emergency care for work-related injuries 24 hours a day, 365 days a year. Follow-up care is normally scheduled at the Occupational Health Services department most convenient to you.

For more information, call Kaiser On-the-Job® Member Services:
808-432-2208 (Oahu)
1-888-683-2208 (neighbor islands)

VISION ESSENTIALS BY KAISER PERMANENTE

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

Oahu

Honolulu Medical Office
1010 Pensacola St.
Honolulu, HI 96814
Optical Dispensing:
808-432-2170
Appointments:
808-432-2600

Kailua Clinic
201 Hamakua Dr., Bldg. B
Kailua, HI 96734
Optical Dispensing:
808-432-3461
Appointments:
808-432-3400

Waipio Medical Office
94-1480 Moaniani St.
Waipahu, HI 96797
Optical Dispensing:
808-432-3126
Appointments:
808-432-3100
Maui
Kihei Clinic
1279 S. Kihei Rd., #120
Kihei, HI 96753
Optical Dispensing: 808-891-6828
Appointments: 808-891-6800
Lahaina Clinic
910 Wainee St.
Lahaina, HI 96761
Optical Dispensing: 808-662-6925
Appointments: 808-662-6900
Wailuku Medical Office
80 Mahalani St.
Wailuku, HI 96793
Optical Dispensing: 808-243-6203
Appointments: 808-243-6200

Big Island
Hilo Clinic
1292 Waianuenue Ave.
Hilo, HI 96720
Optical Dispensing: 808-934-4050
Appointments: 808-334-4420
Kona Medical Office
74-517 Honokohau St.
Kailua-Kona, HI 96740
Optical Dispensing: 808-334-4420
Appointments: 808-334-4420

Contact lens orders:
808-432-2610 (Oahu)
1-866-424-7908 (neighbor islands)
Or visit us at kp2020.org
(for contact lens refill orders)

EYE CARE COVERAGE IN BASE BENEFIT
All Kaiser Permanente members have an eye exam benefit as part of the base health plan coverage. The eye exam screens for eye conditions related to injuries or diseases of the eye, including glaucoma or cataracts. Also included are routine eye examinations for eyeglasses. Your eye exam information as well as your corrective vision prescription are stored in your electronic medical record, which is accessible to your entire Kaiser Permanente health care team.

For information about your optical benefits, please review your Benefits Summary or call Member Services. If eligible, you may apply your Kaiser Permanente optical benefit toward eyeglasses or contact lens purchases. To make an appointment for eye examinations, call an optical center location that is convenient for you. Appointments are not necessary to order eye glasses. For optical center locations, check the Added Choice Physicians and Locations Directory or visit kp2020.org.

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

THE HEARING SERVICE CENTER BY KAISER PERMANENTE
Ordering and fitting of nationally recognized hearing aids by doctors of audiology are available to members and the general public at our Honolulu, Kailua, Waipio, and Wailuku facilities. Updated assistive listening technology and equipment are also available. Most Kaiser Permanente members typically have coverage for medically necessary hearing examinations. Refer to your Benefits Summary for a description of coverage.

808-432-2155 (Oahu)
808-243-6191 (Maui)

Visit us at: kp.org/hearingservice/hi
Email us at: HI.Hear@kp.org

*Kaiser Permanente members typically have coverage for medically necessary eye and hearing examinations, which are generally conducted at Kaiser Permanente facilities. Otherwise, the services described here are provided on a fee-for-service basis, separate from and not covered under your health plan benefits. Clinical services are provided by providers or contractors of Hawaii Permanente Medical Group, Inc. Results of services vary among patients and cannot be guaranteed. Hawaii Permanente Medical Group, Inc., Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals have a
financial interest in the provision of these services. For specific information about your health plan benefits, please see your Benefits Summary.

Oahu

**Honolulu Medical Office**  
Honolulu Medical Office  
1010 Pensacola St.  
Honolulu, HI 96814

- Hearing Test: 808-432-8000  
- Hearing Aid Consultation: 808-432-2155

**Kailua Clinic**  
201 Hamakua Dr., Bldg. B  
Kailua, HI 96734

- Hearing Test: 808-432-8000  
- Hearing Aid Consultation: 808-432-2155

**Waipio Medical Office**  
94-1480 Moanani St.  
Waipahu, HI 96797

- Hearing Test: 808-432-8000  
- Hearing Aid Consultation: 808-432-2155

Maui

**Wailuku Medical Office**  
80 Mahalani St.  
Wailuku, HI 96793

- Hearing Test: 808-243-6200  
- Hearing Aid Consultation: 808-243-6191

THE VISION CORRECTION CENTER BY KAISER PERMANENTE

**LASIK VISION CORRECTION**

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

PREMIUM INTRAOCULAR LENS IMPLANTS (IOL)

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

808-432-2600 (Oahu)  
1-888-699-3937 (toll free from the neighbor islands: to leave messages for call-back)

Visit us at: kp.org/visioncenter/hi  
Email us at: HI.Eyes@kp.org

THE AESTHETIC CENTER BY KAISER PERMANENTE

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

808-432-5670 (Oahu)  
1-866-400-1760 (toll free from the neighbor islands)

Visit us at: kp.org/aesthetic/hi  
Email us at: HI.TACPlastics@kp.org

COSMETIC SKIN CARE SERVICES

Our cosmetic skin care services vary by location and include:

- State-of-the-art laser treatments for skin resurfacing, brown spots reduction, and hair reduction
- Injectables for wrinkles, including Botox®, Dysport®, Restylane®, Juvederm®, Perlane®, and Sculptra®
- Aesthetician services for microdermabrasion, facial peels, pharmaceutical-grade skin care products, and complimentary skin care evaluations by an aesthetician
COSMETIC PLASTIC SURGERY SERVICES

Surgical procedures for cosmetic plastic surgery is performed on Oahu and Maui. Pre-op, post-op, and recheck services may be offered on your home island. All travel charges are the responsibility of the patient.

- Procedures for the Body include: Arm Lift, Body Lift, Breast Augmentation, Breast Lift, Liposuction, Tummy Tuck
- Procedures for the Face and Neck include: Brow Lift, Eyelid Tuck, Face Lift, Neck Lift, Nose Reshaping.

For a more comprehensive list of procedures, visit the Aesthetic Center website.

COSMETIC PLASTIC SURGERY

Our board-certified plastic and reconstructive surgeons perform:

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

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

GETTING CARE OUTSIDE OF HAWAII

Services that are not covered at the in-network benefit level by Kaiser Permanente may be eligible for coverage by KPIC at the out-of-network benefit level.

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

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

If you think you’re having a medical emergency, go immediately to the Emergency Department. We cover emergency care from Kaiser Permanente providers and non-Kaiser Permanente providers anywhere in the world, subject to your plan terms. If you think you need an ambulance, call 911. Ambulance service will be paid according to your plan benefits when it is determined to be medically necessary.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

For more information about emergency care under your Added Choice plan, please see page 15 of this handbook and refer to your plan Benefits Summary and KPIC Certificate of Insurance.
As an Added Choice member, you may receive medical services at Kaiser Permanente facilities in our other regions when you are visiting the area. Visiting member services are different from the coverage you receive in your home region. Be sure you have your Kaiser Permanente Added Choice ID card with you at all times. The visiting member program is not a plan benefit but a service offered to members as a courtesy. Changes to the program may occur at any time. For locations of Kaiser Permanente facilities in our other regions, please go to kp.org or contact Member Services at 1-800-966-5955.

**HOW TO FILE AN APPEAL ON A PRECERTIFICATION DECISION FOR OUT-OF-NETWORK SERVICES**

If you or your provider wishes to appeal a precertification decision for coverage of out-of-network services, you may do so by writing:

Permanente Advantage  
5855 Copley Dr., Ste. 250  
San Diego, CA 92111  
Phone: 1-888-529-1553  
Fax: 1-866-338-0266

Permanente Advantage must receive your review request within 180 days of your receiving notice of denial of precertification. The 180 days starts five business days from the date of the denial notice to allow for delivery time, unless you can prove that you received the notice after that five-day business period. A final determination will be made within 15 days for pre-service, or 72 hours for an expedited appeal. Final determinations on a retroactive appeal will be made within 30 days.

**HOW TO FILE AN APPEAL ON A CLAIMS DECISION ABOUT IN-NETWORK BENEFITS**

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

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

You may file your appeal by mailing or delivering your request to:

Kaiser Foundation Health Plan, Inc.  
Attn: Regional Appeals Office  
711 Kapiolani Blvd.  
Honolulu, HI 96813

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

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

When received, your appeal will be prepared for an internal review. Appeal reviews will consider all information you submit (whether or not that information was submitted with your initial appeal).
request for payment or coverage), will be decided by a different reviewer than the person who denied your initial request, and will not give deference to the initial decision you’re appealing. When you appeal, you may give testimony in writing or by telephone. Please call Member Services to get information about giving testimony by phone. If we consider, rely upon, or generate any new or additional evidence in our appeal review, or if our appeal decision is based on a new or additional coverage rationale, we will provide you, free of charge, such evidence or coverage rationale as soon as possible and give you a reasonable opportunity to respond before our decision is due. If you do not respond before we must make our decision, our decision will be based on the information that we have on hand. If we continue to deny your request after our appeal is completed, our written notice to you will include the specific reasons for the decision and refer to the specific plan provisions on which our decision was made. If you are not satisfied with our decision, you may request external review as noted later in this section.

Appeals related to claims for payment (post-service requests) filed by members on employer group plans will be processed through two internal levels of review. When received, your post-service appeal will be prepared for a first-level review. Generally, we will provide you with our written decision within 30 calendar days. If you are not satisfied with the first-level decision, you may request a second-level review by our Regional Appeals Committee within 60 days of the date of the first-level decision letter. We'll acknowledge receipt of your second-level appeal and provide you with our written decision within 30 calendar days of our receipt of the request.

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

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

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

Language assistance available in languages mandated by the federal Affordable Care Act:

Para obtener asistencia en Español, llame al 1-800-966-5955.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-966-5955.

如 果 需 要 中 文 的 帮 助, 拨 打 1-800-966-5955.
HOW TO FILE AN APPEAL ON A CLAIMS DECISION FOR OUT-OF-NETWORK BENEFITS

STANDARD APPEAL
If we deny your request for payment or coverage for out-of-network services you have received from a contracted or non-contracted provider, you have the right to file an appeal and ask that we reconsider our decision. Generally, we’ll issue a written notice that tells you the specific reasons we denied payment or coverage for the item or service. The notice describes your appeal rights and how to file an appeal. You must submit your appeal within 180 days of the date of our denial notice.

Appeals filed by members on non-group or individual plans (Obtained ON or OFF the Marketplace) members will be completed through a single level review and decisions communicated in writing within 60 calendar days of receipt of the appeal. You may appoint someone to file the appeal on your behalf. If you choose to appoint a representative, you must name this person in writing and state that he or she may file the appeal on your behalf. Both you and your representative must sign this statement, unless the person is your attorney. When necessary, your representative will have access to medical information about you that relates to the request. If you prefer, you may call Member Services at 1-800-966-5955 to request an Appointment of Representative form.

You may file your appeal by mailing or delivering your request to:
Kaiser Permanente Added Choice
P.O. Box 261205
Plano, TX 75026-1205

You should include in your appeal your name, your Kaiser Permanente medical record number, the date, the nature of our decision that you are appealing, and all comments, documents, and other information you want us to consider regarding your appeal.

When received, your appeal will be acknowledged and prepared for a first-level review. Generally, we’ll provide you with our written decision in 30 calendar days. Our decision will include the specific reason for the decision and reference to the specific plan provisions on which our decision is made. If you are not satisfied with the first-level decision, you may request a second-level review within 60 days of the date of the first-level decision letter. We’ll provide you with our written decision in 30 calendar days of our receipt of your request for a second-level review.

EXPEDITED APPEAL
You may ask that we make an expedited decision on your appeal for out-of-network benefits. The expedited procedure applies to denied requests for services or supplies that you believe we should provide or arrange. This procedure does not apply to denied requests for payment for services that you have already received. We’ll make an expedited decision within 72 hours if we find, or if your physician states, that your health or ability to regain maximum function could be seriously harmed by waiting 30 days for a decision. Our decision may take longer if we have to wait for medical information from a non-Kaiser Permanente or non-contracted provider, but we’ll make a decision within 72 hours of our receipt of such medical information.

You or your physician may request an expedited appeal anytime by calling 1-866-233-2851 toll free, or by faxing, writing, or delivering your request to the same address and phone numbers listed for standard appeals. If we determine that your request does not meet the criteria for an expedited appeal, we’ll automatically review your written appeal under the 30-day process.

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

**FILING AN EXTERNAL APPEAL WITH AN INDEPENDENT REVIEW ORGANIZATION**

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

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

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

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

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

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

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

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

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

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

EXTERNAL REVIEW REQUESTS FOR EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR TREATMENTS

Additional procedures apply to a request involving an experimental or investigational service or treatment. You or your authorized representative may make an oral request for expedited review if your treating physician certifies in writing that the service or treatment you are requesting would be significantly less effective if it was not initiated promptly. This certification must be filed promptly with the commissioner following your oral request for review. If you or your authorized representative request expedited review in writing rather than orally, you must include your treating physician’s written certification with the written request. If your request is determined eligible for expedited review, the commissioner must immediately assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must transmit to the IRO in an expeditious manner all the documents and information that we considered during our internal review of your request.

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

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

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

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

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

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

FILING AN EMERGENCY CARE CLAIM FOR PAYMENT

Emergency services are reviewed for payment first at the in-network benefit level. All of the following criteria must be met in order for in-network benefits to apply:

- Care was a covered service under your Group Medical and Hospital Service Agreement.
- Services met the prudent layperson definition of an emergency:
  - The services were immediately required because it was a sudden and unforeseen illness or injury; and
  - Any delay caused by going to see a Kaiser Permanente practitioner would have resulted in death, serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or placed your health in serious jeopardy.
- The emergency number on the back of your Kaiser Permanente Added Choice ID card was called within 48 hours (or as soon as reasonably possible) after your admittance to a hospital other than the Kaiser Permanente Moanalua Medical Center.
- Arrangements were made for transfer to an in-network/designated facility and a Kaiser Permanente in-network provider as soon as it was medically appropriate.

You may elect to receive care after the initial Emergency Department stabilization from a non-Kaiser Permanente provider, but it will be considered for coverage at the out-of-network benefit level and the applicable annual deductible and coinsurance will apply.

We review claims for out-of-plan emergency care and out-of-area urgent care after the services have been provided. If you, your family members, or practitioners call us during an emergency or urgent episode, we’ll confirm your membership status. However, we will not authorize coverage or payment at that time.

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

If you paid for services, you may file a claim by sending your name, the patient’s name and health plan medical record number, paid receipts, medical documentation, and a written statement describing the sequence of events to the following address within 90 days (or as soon as reasonably possible) after you received the out-of-plan emergency or out-of-area urgent care:
You may appoint someone to file the claim on your behalf. If you choose to appoint a representative, you must name this person in writing and state that he or she may file the claim on your behalf. Both you and your representative must sign and date this statement, unless the person is your attorney. When necessary, your representative will have access to your medical information as it relates to the request. If you prefer, you may call Member Services at 1-800-966-5955 for an Appointment of Representative form.

Our standard in-network decision will be made within 30 calendar days from the date Health Plan received your post-service claim for payment. If Health Plan cannot make its decision within the standard allotted time because Health Plan does not have sufficient information or because of other special circumstances, Health Plan will send you a written notice of the additional information needed to determine coverage. If Health Plan determines that your claim is not covered, it will send you a denial notice, which will include the specific reason for the denial, refer to the in-network provisions on which its denial is based, and your appeal rights. If you disagree with the denial decision, you can file an in-network appeal by following the appeal procedures described in the “How to file an appeal on a claims decision about in-network benefits” section on page 34.

You may request a free copy of (1) all documents and information relevant to your request for payment or coverage; (2) any rule, guideline, or protocol Health Plan relied upon in denying the service or supply you requested; and (3) the identity of any experts whose advice was obtained by us in connection with our denial of your request. You can request the information by calling Member Services at 1-800-966-5955.
FILING APPEALS, CLAIMS, AND REQUESTS

does not show entitlement to the coverage or payment you request, this could result in an adverse decision.

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

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

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

You, your authorized representative, or treating physician may request an expedited decision anytime by calling toll-free 1-866-233-2851, or by faxing, writing, or delivering your request to the same address listed for standard decisions. Our fax number is 808-432-5691. The fax number for appeals is listed in the “How to file an appeal” section on page 34.

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

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

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

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

1. This includes but is not limited to any claim asserted:

   (a) By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the Member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed (“Member Parties”). For purposes of this section, all family members of the Member or patient who have derivative claims arising from such harm, shall also be deemed “Member Parties” and bound to these arbitration terms;

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

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

      (i) Kaiser Foundation Health Plan, Inc.,

      (ii) Kaiser Foundation Hospitals,

      (iii) Hawaii Permanente Medical Group, Inc.,

      (iv) The Permanente Federation, LLC,

      (v) The Permanente Company, LLC,

      (vi) Any individual or organization that contracts with an organization named in (i), (ii), (iii), (iv) or (v) above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

2. Notwithstanding any provisions to the contrary in this Service Agreement, the following claims shall not be subject to mandatory arbitration:

   (a) claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;

   (b) actions for appointment of a legal guardian of a person or property subject to probate laws;

   (c) purely injunctive orders reasonably necessary to protect Kaiser Permanente’s ability to safely render medical services under this Service Agreement (such as temporary restraining orders, and emergency court orders).

B. INITIATING ARBITRATION

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

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

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

3. Limited civil discovery shall be permitted only for

(a) production of documents that are relevant and material,

(b) taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and

(c) independent medical evaluations.

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

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

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

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

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

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

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

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

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

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

For detailed information about your rights to privacy, please refer to the Notice of Privacy Practices. You can find the Notice of Privacy Practices on our website at kp.org/privacy, or contact Member Services at 1-800-966-5955.

YOU HAVE A RIGHT TO:

- Receive information about Kaiser Permanente, our services, our health care practitioners and providers, and your rights and responsibilities.
- Get information about the people who provide health care including their names, professional status, and board certification.
- Be treated with consideration, compassion, and respect taking into account your dignity and individuality, including privacy in treatment and care.
- Be free from neglect, exploitation, and verbal, mental, physical, and sexual abuse.
- Make decisions about your medical care. This includes advance directives to have life-prolonging medical or surgical treatment given, ended, or stopped, withholding resuscitative services; and care at the end of life. You have the right to assign another person to make health care decisions for you, to the extent allowed by law.
- Discuss all medically necessary treatment options, regardless of cost or benefit coverage.
- Voice your complaints freely without fear of discrimination or retaliation. If you are not satisfied with how your complaint was handled, you may have us reconsider your complaint.
- Make recommendations regarding Kaiser Permanente’s Member Rights and Responsibilities statement.
- Be involved and include your family in the planning of your medical care. You have the right to be informed of the risks, benefits, and consequences of your actions. You may refuse to participate in research, investigation, and clinical trials.
- Refuse care, treatment, and services.
- Choose your primary care physician, change your primary care physician, or obtain a second opinion within Kaiser Permanente. You also have the right to consult with a non-Plan doctor at your own expense.
- Establish a relationship with a specialist or qualified practitioner of women’s health services to assure your continuing care for specific conditions.
- Receive information and discuss with your physician your medical condition, available treatment options, alternatives, and diagnosis in a manner appropriate to your condition and your ability to understand.
- Obtain language interpretation services when required to understand your care and services.
- Be involved in the consideration of bioethical issues. You have the right to contact our Bioethics Committee for help in resolving ethical, legal, and moral matters relating to your care.
- Be informed of the relationship between Kaiser Permanente and other health care programs, providers, and schools.
- Be informed about how new technologies are evaluated in relation to benefit coverage.
- Receive the medical information and education you need to participate in your health care.
- Give informed consent before the start of any procedure or treatment.
- Give or withhold informed consent to produce or use recordings, films, or other images of yourself for purposes other than your care.
- Have access to medically necessary services and treatment, including emergency treatment, and covered benefits, in a timely and fair way. Services should not be arbitrarily denied or reduced in amount, duration, or scope because of diagnosis, type of illness, or condition.
- Receive services in a coordinated manner. Your primary care physician (PCP) is in charge of coordinating your care.

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YOUR RIGHTS AND RESPONSIBILITIES

of your medical care. Your PCP treats you, refers you to specialists when needed, and connects you to all of our services. Your doctor will work with you to help you meet your health goals so that you can live well.

- Have your cultural, psychological, social, and spiritual needs considered and respected.
- Be assured of privacy and confidentiality of all communications and records related to your care, and have your confidentiality protected. You or a person of your choosing can request and receive a copy of or access your medical records and request to amend or correct the record, within the limits of the law. In addition, you have the right to limit, restrict, or prevent disclosure of protected health information (PHI).
- Be treated in a safe, secure, and clean environment free from physical and drug restraints, except when ordered by a doctor or in the case of an emergency, when it is necessary to protect you or others from injury.
- Receive appropriate and effective pain management as an important part of your care plan.
- Get an explanation of your bill and benefits regardless of how you pay. You have the right to know about our available services, referral procedures, and costs.
- Receive other information and services required by various state or federal programs.
- Be informed about the outcomes of care, when appropriate, including unanticipated outcomes. And to be informed of the ability to change providers if other qualified providers are available.
- Discuss “do not resuscitate” wishes or advance directive instructions for health care with your surgeon and anesthesiologist prior to an operative procedure when you wish to have the “do not resuscitate” honored in the event of a life-threatening emergency during an operative procedure.
- File a complaint or voice a concern. Medicaid patients receiving services, including in the Ambulatory Surgery Center, who wish to file a complaint or voice a concern may contact the Medicaid Ombudsman, Hilopaa, at hilopaa.org, or by calling 1-808-791-3467 (Oahu), or 1-808-270-1536 (Maui). Medicare patients may contact the Office of the Medicare Beneficiary Ombudsman at medicare.gov.

AS A PARTNER IN YOUR HEALTH CARE, YOU HAVE THE FOLLOWING RESPONSIBILITIES:

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

party payments.
• Inform us when you or your covered dependents change addresses or other contact information.
• Be responsible for your actions. If you refuse treatment, do not follow instructions, and if your action or behavior interferes with facility and/or patient care, your care may be rescheduled. Should your medical condition change, the treatment plan may be modified.
• For Ambulatory Surgery Center (ASC) patients, provide a responsible adult to transport you home from the ASC and remain with you for 24 hours, if required by your provider.

HOSPITAL PATIENT RIGHTS

As a patient in the Moanalua Medical Center, you also have the right to:
• Receive information about your rights and responsibilities when you are admitted.
• Receive orderly transfer and discharge for your welfare, for other patients’ welfare, or other causes as determined by your physician. You have the right to receive reasonable advance notice and discharge planning by qualified hospital staff to help ensure appropriate post-hospital placement and care.
• Request visits by clergy at any time and participate in social and religious activities, unless doing so infringes on the rights of other patients or would compromise your medical care.
• Receive and use your own clothing and possessions as space permits, unless doing so infringes on the rights of other patients, is in violation of hospital safety practices, or would compromise your medical care.
• Give informed consent before the start of any recording, films, or other images for purposes of non-patient care.
• Access protective and advocacy services.
• Access appropriate educational services when a child or adolescent patient’s treatment necessitates a significant absence from school.

• Protection from requests to perform services for Kaiser Foundation Hospital that are not included for therapeutic purposes in your plan of care.
• Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation as specified in federal regulations on the use of restraints and seclusion.
• Receive visitors of your choice including a spouse, (same-sex) domestic partner, family member, or friend. All or certain visits may be excluded at your request or discretion of staff, physicians, or administration to allow for your and others’ rights, safety, or well-being.
• File a complaint in the hospital, either verbally or in writing, with the department manager or supervisor. If you are not satisfied with the response, you may contact Hospital Administration, which is located on the first floor of the hospital or reached through the operator at 432-0000.
• You may also contact The Joint Commission (an independent, not-for-profit organization that accredits and certifies health organizations and programs) by phone, mail, fax, or email.

Phone: toll free U.S., weekdays 8:30 a.m.–5 p.m. Central time, 1-800-994-6610.

Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.

Fax: 630-792-5636.
Email: complaint@jointcommission.org
THIRD-PARTY LIABILITY
Kaiser Permanente has the right to recover the cost of care for a member’s injury or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the member by an insurance company, individual, or other third party.

ELIGIBILITY, ENROLLMENT, AND TERMINATION OF YOUR MEMBERSHIP
Detailed information on enrollment, eligibility, and membership termination topics listed below are included in your Service Agreement. You may obtain a copy of your Service Agreement by calling Member Services at 1-800-966-5955.

• Who may enroll
• Timely enrollment
• Effective date for newborns
• Effective date for newborns/children who are subject to a petition to adopt
• Who is eligible for this plan
• Loss of eligibility
• Termination of your membership
• Termination for discontinuance of a particular plan
• Special enrollment

IF YOU BECOME ELIGIBLE FOR MEDICARE
Medicare is the federal health insurance program for people age 65 or older, some people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant. To obtain information about your eligibility or benefits under Original Medicare, you may call toll free 1-800-MEDICARE (1-800-633-4227) or TTY 711, or visit the medicare.gov website. Medicare customer service representatives are available 24 hours a day, 7 days a week.

There are federal regulations that mandate when Medicare will act as a secondary or primary payer in coordination with your Added Choice plan. While Medicare is your secondary payer, you may remain eligible for coverage under your Added Choice Plan. When Medicare becomes your primary payer, you will not be eligible for the Added Choice plan. Generally, Medicare is the primary payer for:
• Retirees age 65 and over
• The dependent spouse of a retiree age 65 and over
• Current employee of a group with less than 20 employees
• Totally disabled dependents covered by Social Security Disability

When you become eligible for Medicare, you may also be eligible for enrollment in our Medicare Advantage plan called Kaiser Permanente Senior Advantage. Prospective Senior Advantage plan enrollees must reside in the Hawaii service area of Oahu, Maui, and Hawaii (except for ZIP codes 96718, 96772, and 96777). For more information about whether you qualify to enroll in Senior Advantage, please call Member Services at 1-800-805-2739 from 8 a.m.–8 p.m., 7 days a week. TTY only, call 711.

When your Medicare becomes primary or when you enroll in Senior Advantage, your Added Choice plan membership will be terminated.
Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. We also:

- **Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- **Provide no cost language services to people whose primary language is not English, such as:**
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number provided below.

**1-888-251-7052**
**TTY: 711**

If you believe that KPIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the KPIC Civil Rights Coordinator, Grievance 1557, 5855 Copley Drive, Suite 250, San Diego, CA 92111, telephone number **1-888-251-7052**. You can file a grievance by mail or phone. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 1-800-537-7697** (TDD). Complaint forms are available at [http://www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).
Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- **Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- **Provide free language services to people whose primary language is not English, such as:**
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number provided below to talk to an interpreter.

1-800-966-5955
TTY: 711

If you believe that Kaiser Foundation Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Kaiser Civil Rights Coordinator, 711 Kapiolani Blvd, Honolulu, HI 96813, telephone number: 1- 800-966-5955. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Help in your Language

**English:** You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or if this is a notice that requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

**Arabic:** لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن هكذا أو تنطبق أن تقدمها، أو إذا كان هذا الإشعار الذي يتطلب منك إجراء خلال تاريخ محدد، يرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

<table>
<thead>
<tr>
<th>State</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>California</td>
<td>1-800-464-4000</td>
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<td>Colorado</td>
<td>1-800-632-9700</td>
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<td>District of Columbia</td>
<td>1-800-777-7902</td>
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<td>Georgia</td>
<td>1-888-865-5813</td>
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<td>Hawaii</td>
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<td>Washington</td>
<td>1-800-813-2000</td>
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<tr>
<td>TTY</td>
<td>711</td>
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</tbody>
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Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232. • Kaiser Permanente Insurance Company (KPIC), Ordway Building, One Kaiser Plaza, Oakland, CA 94612

60436922 National 2016 KPIC-TL16-001-CO-GA-HI-MAS
Have questions?
Call us at 1-800-494-5314.

• Go to buykp.org/apply.
• Or contact your agent or broker.

Kaiser Permanente for Individuals and Families
60436922 National 2016 KPIC- TL16-001-CO-GA-HI-MAS
Kaiser Permanente Added Choice Member Handbook

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Have questions? Call us at 1-800-494-5314. Go to buykp.org/apply. Or contact your agent or broker.

Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente. In caso di domande riguardanti la tua richiesta o la copertura attraverso Kaiser Permanente, o se occorre intervenire entro una data specifica secondo quanto indicato in questa comunicazione, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 어느 날짜까지 조치를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락하여 통역서비스에 문의하십시오.

ocumented (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຽຄ່າ. ຖ້າວ່າ ທ່ານມີຄໍາຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງຜ່ານ Kaiser Permanente, ຫຼືຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດໍາເນີນການພາຍໃນວັນທີທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດຫຼື ເຂດຂອງທ່ານ ການຂໍ້ມູນການສະໝັກຂອງທ່ານ.

Farsi (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در سوالاتی که پس از اعلام Kaiser Permanente باید انجام دهید، یا این اعلامیه بر اساس آن اعمالی باشد تا تاکید شوید که شما درخواست واقعی ای که برای کمک خود را دردسر ساز کرده‌اید را ارائه نمی‌دهید.

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa'e irratti tarkaanfii akka ati fudhattacha gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa'e irratti tarkaanfii akka ati fudhattacha gaaffii yoo qabaatte.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalemalap ohng aplikeisn de iren audpe eke ohng Kaiser Permanente, de ma pakair wet me anahne komwi en mwekid ohng rahm me kileledi, ah komw anahne koahl nempe me sansalehr ohng owmi palien wehi pwe komwi en lokaiaieng owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre sua solicitação ou cobertura por meio da Kaiser Permanente, ou se este aviso exigir que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.
Have questions? Call us at 1-800-494-5314.

- Go to buykp.org/apply.
- Or contact your agent or broker.

Visit us at kp.org
For more information about Kaiser Permanente and other services, please call us at one of the numbers below:

**KAISER PERMANENTE MEMBER SERVICES**
Oahu and neighbor islands..................1-800-966-5955
TTY (toll free)............................................711

Monday–Friday, 8 a.m.–5 p.m.
Saturday, 8 a.m.–noon

**ADDED CHOICE HELPLINE........1-800-238-5742**
• Press 1 for claims (Monday–Friday, 4 a.m.–3 p.m.)
• Press 2 for precertification (24 hours a day, 7 days a week)
• Press 3 for Member Services (Monday–Friday, 8 a.m.–5 p.m.; Saturday, 8 a.m.–noon)