

**Kaiser Permanente Group Plan
HSTA VB Plan
2017 Benefits summary**

This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer’s applicable Face Sheet, Group Medical and Hospital Service Agreement, benefit schedule, and riders (collectively known as “Service Agreement”). The Service Agreement is the legally binding document between Health Plan and its members. In event of ambiguity, or a conflict between this summary and the Service Agreement, the Service Agreement shall control. Senior Advantage members must refer to their Kaiser Permanente Senior Advantage Evidence of Coverage for a description of their benefits.

You are covered for Medically Necessary services at Kaiser Permanente facilities within the Hawaii service area, and which are provided, prescribed or directed by a Kaiser Permanente physician and consistent with reasonable medical management techniques specified under this plan with respect to the frequency, method, treatment or licensing or certification, to the extent the provider is acting within the scope of the provider’s license or certification under applicable state law. All care and services need to be coordinated by a Kaiser Permanente physician except for emergency services, urgent care or services authorized by a written referral.

Riders, if any, are described after the Exclusions and Limitations sections.

If you receive covered services and items in one of these seven care settings, you only pay a single copay or coinsurance: hospital, observation, outpatient surgery and procedures in an ambulatory surgery center or outpatient hospital-based setting, skilled nursing facility, dialysis, radiation therapy and emergency room services. However, services and items received during an emergency room visit are included in the copay or coinsurance for emergency services, except complex imaging services (including interpretation of imaging) are covered under the complex imaging benefit.

For settings that are not mentioned above, each medical service or item is covered in accord with its relevant benefit section. For example, drugs or laboratory services related to in vitro fertilization are not covered under the in vitro fertilization benefit. Drugs related to in vitro fertilization are covered under the prescribed drugs benefit section. Laboratory services related to in vitro fertilization are covered under the laboratory services benefit section.

Section	Benefits	You pay
Supplemental charges maximum **	Your copays and coinsurance for covered Basic Health Services are capped by a supplemental charges maximum	\$2,000 per member, \$6,000 per family unit (3 or more members) per calendar year
Deductible	Deductible **	None
Outpatient services	Office visits ** <ul style="list-style-type: none"> • For primary care • With a Specialist Outpatient surgery and procedures <ul style="list-style-type: none"> • Provided in medical office during a primary care visit • Provided in medical office with a Specialist • Provided in an ambulatory surgery center (ASC) or hospital-based setting • Routine pre- and post-surgical office visits in connection with a covered surgery Telehealth	\$15 per visit \$15 per visit \$15 per visit No Charge Applicable cost shares apply. See applicable benefit sections†
	Allergy testing Allergy treatment materials that are on Kaiser Permanente’s formulary and require skilled administration by medical personnel	\$15 per visit No charge

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* See Coverage Exclusions Section

** See Coverage Limitations Section

Section	Benefits	You pay
	<p>Chemotherapy, includes the treatment of infections or malignant diseases</p> <ul style="list-style-type: none"> Office visits Chemotherapy infusions or injections that require skilled administration by medical personnel Self-administered oral chemotherapy <p><i>Note: In accordance with state law, oral chemotherapy will be administered at the same or lower cost share as intravenous chemotherapy.</i></p>	<p>\$15 per visit</p> <p>No charge</p> <p>Self-administered/take home drug copay (if you have a drug rider) or No charge (if you do not have a drug rider)</p>
	<p>* Physical, occupational and speech therapy **</p> <p><i>Note: includes short-term therapy only (ie. habilitative services are not covered)</i></p>	<p>\$15 per visit</p>
	<p>Autism services**</p>	<p>Applicable cost shares apply. See applicable benefit sections†</p>
	<p>Dialysis</p> <ul style="list-style-type: none"> Kaiser Permanente physician and facility services for dialysis Equipment, training and medical supplies for home dialysis 	<p>10% of applicable charges</p> <p>No charge</p>
	<p>Materials for dressings and casts</p>	<p>Applicable cost shares apply. See applicable benefit sections†</p>
Outpatient laboratory, imaging, and testing services	<p>Laboratory services **</p>	<p>\$15 per day</p>
	<p>Imaging services **</p> <ul style="list-style-type: none"> General radiology Specialty imaging services 	<p>\$15 per day</p> <p>\$15 per day</p>
	<p>Testing services**</p>	<p>\$15 per day</p>
Outpatient radiation therapy	<p>Radiation therapy **</p>	<p>\$15 per visit</p>
Observation	<p>Observation</p>	<p>No charge</p>
Hospital inpatient care	<p>Hospital inpatient care **</p>	<p>No charge</p>
	<p>* Physical, occupational and speech therapy **</p> <p><i>Note: includes short-term therapy only (ie. habilitative services are not covered)</i></p>	<p>Included in the above hospital inpatient care cost share</p>
Transplants	<p>* Transplants **</p>	<p>Applicable cost shares apply. See applicable benefit sections†</p>

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Section	Benefits	You pay
Preventive care services	<p>Preventive care services (which protect against disease, promote health, and/or detect disease in its earliest stages before noticeable symptoms develop), including:</p> <ul style="list-style-type: none"> • Screening services for Grade A and B recommendations of the U.S. Preventive Services Task Force (USPSTF), such as: <ul style="list-style-type: none"> • Preventive counseling services • Screening laboratory services • Screening radiology services • FDA approved contraceptive drugs and devices** that are available on the Health Plan formulary, as required by the federal Patient Protection and Affordable Care Act (PPACA). Coverage of all other FDA approved contraceptive drugs and devices are described in the Prescribed drugs section. • Female sterilizations** • Purchase of breast feeding pump, including any equipment that is required for pump functionality <p><i>A complete list of preventive care services provided at no charge is available through Member Services. This list is subject to change at any time. If you receive any other covered services during a preventive care visit, you will pay the applicable charges for those services.</i></p> <p>Preventive care office visits for:</p> <ul style="list-style-type: none"> • Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, and 5 years) • One preventive care office visit per calendar year for members 6 years of age and over • One gynecological office visit per calendar year for female members 	No charge (non-preventive care services according to member's regular plan benefits)
Prescribed drugs	<p>Prescribed drugs that require skilled administration by medical personnel, such as injections and infusions (e.g. cannot be self-administered) **</p> <ul style="list-style-type: none"> • Provided in a medical office • Provided during other settings, such as hospital stay, outpatient surgery, skilled nursing care <p>Prescribed Self-administered drugs (such as drugs taken orally)</p> <p>Diabetes supplies **</p> <p>Tobacco cessation drugs and products **</p> <p>FDA approved contraceptive drugs and devices **</p> <p>Other drug therapy services</p> <ul style="list-style-type: none"> • Home IV/Infusion therapy ** • Medically necessary growth hormone therapy • Prescribed inhalation therapy <p>Routine immunizations</p>	<p>No charge ▼</p> <p>Applicable cost shares apply. See applicable benefit sections†</p> <p>See attached Drug summary</p> <p>50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)</p> <p>No charge</p> <p>50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply) ▼</p> <p>No charge</p> <p>Applicable cost shares apply. See applicable benefit sections†</p> <p>No charge</p>

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Section	Benefits	You pay
Obstetrical care, interrupted pregnancy, family planning, infertility services, and artificial conception services	Routine obstetrical (maternity) care **	No charge after confirmation of pregnancy
	<ul style="list-style-type: none"> • Routine prenatal visits • Routine postpartum visit • Delivery/hospital stay (uncomplicated) 	
	Non-routine obstetrical (maternity) care , including complications of pregnancy and false labor	Applicable cost shares apply. See applicable benefit sections†
	Inpatient stay and inpatient care for newborn , including circumcision and nursery care, during or after mother's hospital stay (assuming newborn is timely enrolled on Kaiser Permanente subscriber's plan)	Hospital inpatient care cost share apply (see hospital inpatient care section)
	Interrupted pregnancy **	\$15 per visit
	Family planning office visits for female members that are provided in accordance with the Patient Protection and Affordable Care Act	No charge
	All other family planning office visits	\$15 per visit
	Involuntary infertility consultation office visits	Primary care and Specialist office visit copay applies
Artificial conception services		
* In vitro fertilization **	20% of applicable charges	
* Artificial insemination	Primary care and Specialist office visit copay applies	
Sterilization services		
Vasectomy services	Applicable cost shares apply. See applicable benefit sections†	
Reconstructive surgery	Surgery to improve physical function , such as bariatric surgery and surgery to correct congenital defects and birth anomalies	Applicable cost shares apply. See applicable benefit sections†
	Surgery following injury or medically necessary surgery	
	Surgery following mastectomy , including treatment for complications resulting from a covered mastectomy and reconstruction, such as lymphedema	
Home health care and hospice care	Home health care , nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	No charge (office visit copays apply to physician visits)
	Hospice care **	No charge (office visit copays apply to physician visits)
Skilled nursing care *	Skilled nursing care **	No charge for up to 100 days per benefit period
Emergency services	Emergency services ** <u>within</u> and <u>outside the Hawaii service area</u> <i>Note: The copayment for emergency services is waived if you are directly admitted as a hospital inpatient from the emergency department (the hospital copay will apply).</i>	\$50 per visit and 10% of applicable charges for specialty imaging
Urgent care services	Urgent care services **	
	<ul style="list-style-type: none"> • At a Kaiser Permanente (or Kaiser Permanente-designated) urgent care center within the Hawaii service area, for primary care services • At a Kaiser Permanente(or Kaiser Permanente-designated) urgent care center within the Hawaii service area, with a Specialist 	\$15 per visit \$15 per visit

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Section	Benefits	You pay
	<ul style="list-style-type: none"> At a non-Kaiser Permanente facility outside the Hawaii service area 	20% of applicable charges
Ambulance services	Ambulance services **	20% of applicable charges
Blood	Blood and blood processing **	No charge
Mental health services **	Mental health outpatient services, including office visits, day treatment and partial hospitalization services	\$15 per visit
	Mental health hospital inpatient care, including non-hospital residential services	No charge
Chemical dependency services **	Chemical dependency outpatient services, including office visits, day treatment and partial hospitalization services	\$15 per visit
	Chemical dependency hospital inpatient care, including non-hospital residential services and detoxification services	No charge
Health education	General health education services ** , including diabetes self-management training and education	\$15 per visit
Internal prosthetics, devices, and aids **	Implanted internal prosthetics , including fitting and adjustment of these devices, including repairs and replacement other than those due to misuse or loss:	Applicable cost shares apply. See applicable benefit sections†
Durable medical equipment **	Diabetes equipment	50% of applicable charges
	Home phototherapy equipment for newborns	No charge
	Breast feeding pump , including any equipment that is required for pump functionality	No Charge
	All other durable medical equipment	20% of applicable charges
External prosthetic devices and braces **	External prosthetic devices and braces	20% of applicable charges
	A prosthetic device following mastectomy, if all or part of a breast is surgically removed for medically necessary reasons <i>Note: Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.</i>	Applicable internal prosthetics, devices, and aids cost shares apply
Hearing aids **	Hearing aids , provided once every 36 month for each hearing impaired ear	60% of applicable charges
Other medical services and supplies	Anesthesia and hospital services for dental procedures for children with serious mental, physical, or behavioral problems Pulmonary rehabilitation Hyperbaric oxygen therapy Anesthesia services , including general anesthesia, regional anesthesia, and monitored anesthesia for high-risk members Orthodontic services for treatment of orofacial anomalies resulting from birth defects or birth defect syndromes **	Applicable cost shares apply. See applicable benefit sections†
Dependent coverage	Dependent (biological, step or adopted) children of the Subscriber (or the Subscriber's spouse) are eligible up to the child's 26 th birthday. Other dependents may include: 1) the Subscriber's (or Subscriber's spouse's) dependent (biological, step or adopted) children (over age 26) who are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred prior to reaching age 26, and receive 50 percent or more of their support and maintenance from the Subscriber (or Subscriber's Spouse) (proof of incapacity and dependency may be required), or 2) a person who is under age 26, for whom the Subscriber (or Subscriber's spouse), is (or was before the person's 18 th birthday) the court appointed legal guardian.	

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* Coverage exclusions

When a Service is excluded or non-covered, all Services that are necessary or related to the excluded or non-covered Service are also excluded. "Service" means any treatment, diagnosis, care, procedure, test, drug, injectable, facility, equipment, item, device, or supply. The following Services are excluded:

- **Acupuncture.** (This exclusion may not apply if you have the applicable Complementary Alternative Medicine Rider.)
- **Alternative medical Services** not accepted by standard allopathic medical practices such as: hypnotherapy, behavior testing, sleep therapy, biofeedback, massage therapy, naturopathy, rest cure and aroma therapy. (The massage therapy portion of this exclusion may not apply if you have the applicable Complementary Alternative Medicine Rider.)
- **Artificial aids, corrective aids and corrective appliances** such as orthopedic aids, corrective lenses and eyeglasses. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, external prosthetic devices, braces, and hearing aids may be covered benefits). Corrective lenses and eyeglasses may be covered for certain medical conditions, if all essential health benefits are required to be covered. Pediatric vision care services and devices may also be covered as an essential health benefit. (The eyeglasses and contact lens portion of this exclusion may not apply if you have an Optical Rider.)
- **All blood, blood products, blood derivatives, and blood components** whether of human or manufactured origin and regardless of the means of administration, except as stated under the "Blood" section. Donor directed units are not covered.
- **Cardiac rehabilitation.**
- **Chiropractic Services.** (This exclusion may not apply if you have the applicable Complementary Alternative Medicine Rider.)
- Services for **confined members** (confined in criminal institutions, or quarantined).
- **Contraceptive foams and creams, condoms** or other non-prescription substances used individually or in conjunction with any other prescribed drug or device.
- **Cosmetic Services**, such as plastic surgery to change or maintain physical appearance, which is not likely to result in significant improvement in physical function, including treatment for complications resulting from cosmetic services. However, Kaiser Permanente physician services to correct significant disfigurement resulting from an injury or medically necessary surgery, incident to a covered mastectomy, or cosmetic service provided by a Physician in a Health Plan facility are covered.
- **Custodial Services or Services in an intermediate level care facility.**
- **Dental care Services**, including pediatric oral care, such as dental x-rays, dental implants, dental appliances, or orthodontia and Services relating to Craniomandibular Pain Syndrome. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, Services relating to temporomandibular joint dysfunction (TMJ) may be covered). (Part of this exclusion may not apply if you have a Dental Rider.)
- **Employer or government responsibility:** Services that an employer is required by law to provide or that are covered by Worker's Compensation or employer liability law; Services for any military service-connected illness, injury or condition when such Services are reasonably available to the member at a Veterans Affairs facility; Services required by law to be provided only by, or received only from, a government agency.
- **Experimental or investigational Services.**
- **Eye examinations** for contact lenses and vision therapy, including orthoptics, visual training and **eye exercises**. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, habilitative services and pediatric vision care services may be covered). (Eye exams for contact lens may be partially covered if you have an Optical Rider.)
- **Eye surgery** solely for the purpose of correcting refractive error of the eye, such as Photo-refractive keratectomy (PRK), lasek eye surgery, and lasik eye surgery. If your plan is required to cover all essential health benefits, then part of this exclusion does not apply (for example, vision procedures for certain medical conditions may be covered).
- **Routine foot care**, unless medically necessary.
- **Health education:** specialized health promotion classes and support groups (such as weight management and bariatric surgery program).
- **Homemaker Services.**
- The following costs and Services for **infertility consultation services, in vitro fertilization or artificial insemination:**
 - The cost of equipment and of collection, storage and processing of sperm or eggs.
 - In vitro fertilization that does not meet state law requirements.
 - Artificial insemination and in vitro fertilization that do not meet Health Plan and Medical Group requirements and criteria.
 - Services related to conception by artificial means other than artificial insemination or in vitro fertilization, such as ovum transplants, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), including prescription drugs related to such Services and donor sperm and donor eggs used for such Services.
 - Services to reverse voluntary, surgically-induced infertility.
 - Stand-alone ovulation induction Services.

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- **Non FDA-approved drugs and devices.**
- **Certain exams and Services.** Certain Services and related reports/paperwork, in connection with third party requests, such as those for: employment, participation in employee programs, sports, camp, insurance, disability, licensing, or on court-order or for parole or probation. Physical examinations that are authorized and deemed medically necessary by a Kaiser Permanente physician and are coincidentally needed by a third party are covered according to the member's benefits.
- Long term **physical therapy, occupational therapy, speech therapy;** maintenance therapies; routine vision services ; services provided by family or household members; duplicate services provided by another therapy or available through schools and/or government programs.
- **Services not generally and customarily available in the Hawaii service area.**
- **Services and supplies not medically necessary.** A service or item is medically necessary (in accord with medically necessary state law definitions and criteria) only if, 1) recommended by the treating Kaiser Permanente physician or treating Kaiser Permanente licensed health care practitioner, 2) is approved by Kaiser Permanente's medical director or designee, and 3) is for the purpose of treating a medical condition, is the most appropriate delivery or level of service (considering potential benefits and harms to the patient), and known to be effective in improving health outcomes. Effectiveness is determined first by scientific evidence, then by professional standards of care, then by expert opinion. Coverage is limited to the services which are cost effective and adequately meet the medical needs of the member.
- All Services, drugs, injections, equipment, supplies and prosthetics related to treatment of **sexual dysfunction**, except evaluations and health care practitioners' services for treatment of sexual dysfunction.
- Personal comfort items, such as telephone, television, and take-home medical supplies, during covered **skilled nursing care.**
- **Take home supplies** for home use, such as bandages, gauze, tape, antiseptics, ace type bandages, drug and ostomy supplies, catheters and tubing.
- The following costs and Services for **transplants**:
 - Non-human and artificial organs and their transplantation.
 - Bone marrow transplants associated with high-dose chemotherapy for the treatment of solid tissue tumors, except for germ cell tumors and neuroblastoma in children.
- Services for injuries or illness caused or alleged to be caused by **third parties or in motor vehicle accidents.**
- **Transportation** (other than covered ambulance services), **lodging, and living expenses.**
- **Travel immunizations.**
- **Services for which coverage has been exhausted, Services not listed as covered, or excluded Services.**

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** Coverage limitations

Benefits and Services are subject to the following limitations:

- Services may be curtailed because of major disaster, epidemic, or other circumstances beyond Kaiser Permanente's control such as a labor dispute or a natural disaster.
- Coverage is not provided for treatment of conditions for which a member has refused recommended treatment for personal reasons when Kaiser Permanente physicians believe no professionally acceptable alternative treatment exists. Coverage will cease at the point the member stops following the recommended treatment.
- **Ambulance services** are those services which: 1) use of any other means of transport, regardless of availability of such other means, would result in death or serious impairment of the member's health, and 2) is for the purpose of transporting the member to receive medically necessary acute care. In addition, air ambulance must be for the purpose of transporting the member to the nearest medical facility designated by Health Plan for receipt of medically necessary acute care, and the member's condition must require the services of an air ambulance for safe transport.
- **Autism services** are limited to: 1) diagnosis and treatment of and 2) applied behavioral analysis services Treatment for autism will be provided in accord with an approved treatment plan.
- Coverage of **blood and blood processing** includes (regardless of replacement, units and processing of units) whole blood, red cell products, cryoprecipitates, platelets, plasma, and fresh frozen plasma. Rh immune globulin is provided subject to the cost share for skilled-administered prescription drugs. Coverage of blood and blood processing also includes collection, processing, and storage of autologous blood when prescribed by a Kaiser Permanente physician for a scheduled surgery whether or not the units are used.
- **Chemical dependency services** include coverage in a specialized alcohol or chemical dependence treatment unit or facility approved by Kaiser Permanente Medical Group. Specialized alcohol or chemical dependence treatment services include day treatment or partial hospitalization services and non-hospital residential services. All covered chemical dependency services will be provided under an approved individualized treatment plan.
- Members are covered for **contraceptive drugs and devices** (to prevent unwanted pregnancies) only when all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) the drug is one for which a prescription is required by law, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc.
- When applicable, the **deductible** is the amount that members must pay for certain services before Health Plan will cover those services. Services that are subject to the deductible are noted in the "You Pay" column of this benefit summary (for example, if "after deductible" is noted in the "You Pay" column after the copayment, then members or family units must meet the deductible before the noted copayment will be effective). This deductible is separate from any other benefit-specific deductible that may be described herein. For example if prescription drugs are subject to a drug deductible, payments toward that drug deductible do not count toward this medical deductible. Payments toward this medical deductible do not count toward any other benefit-specific deductible (such as a drug deductible). Services that are subject to this medical deductible are: 1) outpatient surgery or procedures provided in an ambulatory surgery center (ASC) or other hospital-based setting, 2) hospital inpatient care, 3) specialty laboratory services, 4) specialty imaging services, 5) skilled nursing care, and 6) emergency services (when noted).
- Up to a 30-consecutive-day supply of **diabetes supplies** is provided (as described under the **prescribed drugs** section) if all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) on the Health Plan formulary and used in accordance with formulary criteria, guidelines, or restrictions, and 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate.
- **Prescribed drugs that require skilled administration by medical personnel** must meet all of the following: 1) prescribed by a Kaiser Permanente licensed prescriber, 2) on the Health Plan formulary and used in accordance with formulary guidelines or restrictions, and 3) prescription is required by law.
- **Durable medical equipment** (such as oxygen dispensing equipment and oxygen, diabetes equipment, home phototherapy equipment for newborns, and breast feeding pump) must be prescribed by a Kaiser Permanente or Kaiser Permanente-designated physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Kaiser Permanente on either a purchase or rental basis, as determined by Kaiser Permanente. Durable medical equipment is that equipment and supplies necessary to operate the equipment which: 1) is intended for repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) is appropriate for use in the home, 4) is generally not useful to a person in the absence of illness or injury, 5) was in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, 6) is not excluded from coverage from Medicare, and if covered by Medicare, meets the coverage definitions, criteria and guidelines established by Medicare at the time the diabetes equipment is prescribed, and 7) is on Kaiser Permanente's formulary and used in accordance with formulary criteria, guidelines, or restrictions. Repair, replacement and adjustment of durable medical equipment, other than due to misuse or loss, is included in coverage. **Diabetes equipment** is limited to glucose meters and external insulin pumps, and the supplies necessary to operate them. Coverage of **breast feeding pump** includes any equipment that is required for pump functionality. If rented or loaned from Kaiser Permanente, the member must return any durable medical equipment items to Kaiser Permanente or its designee or pay Kaiser Permanente or its designee the fair market price for the equipment when it is no

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longer prescribed by a Kaiser Permanente physician or used by the member. Coverage is limited to the standard item of durable medical equipment in accord with Medicare guidelines that adequately meets the medical needs of the member. Convenience and luxury items and features are not covered. The following are excluded from coverage: 1) comfort and convenience equipment, and devices not medical in nature such as sauna baths and elevators, 2) disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages, 3) exercise and hygiene equipment, 4) electronic monitors of the function of the heart or lungs, 5) devices to perform medical tests on blood or other body substances or excretions, 6) dental appliances or devices, 7) repair, adjustment or replacement due to misuse or loss, 8) experimental or research equipment, 9) durable medical equipment related to sexual dysfunction, and 10) modifications to a home or car.

- **Emergency services** are covered for initial emergency treatment only. Member (or member's family) must notify Health Plan within 48 hours if admitted to a non-Kaiser Permanente facility. Emergency Services are those medically necessary services available through the emergency department to medically screen, examine and Stabilize the patient for Emergency Medical Conditions. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity that meet the prudent layperson standard and the absence of immediate medical attention will result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or place the health of the individual in serious jeopardy. Examples of an Emergency Medical Condition include chest pain or other heart attack signs, poisoning, loss of consciousness, convulsions or seizures, broken back or neck, heavy bleeding, sudden weakness on one side, severe pain, breathing problems, drug overdose, severe allergic reaction, severe burns, and broken bones. Examples on non-emergencies are colds, flu, earaches, sore throats, and using the emergency room for convenience or during normal office hours for medical conditions that can be treated in a medical office. Continuing or follow-up treatment for Emergency Medical Conditions at a non-Kaiser Permanente facility is not covered.
- When applicable, **essential health benefits** are provided to the extent required by law and include ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services to the extent required by HHS and EHB-benchmark plan. Pediatric oral care services are covered under this Service Agreement only if a separate Dental Rider is attached (covered services are described within any applicable Dental Rider). A complete list of essential health benefits is available through Member Services. Essential health benefits are provided upon payment of the copayments listed under the appropriate benefit sections (e.g. – office visits subject to office visit copay, inpatient care subject to hospital inpatient care copay, etc.).
- **External prosthetic devices and braces** (including speech generating devices and voice synthesizers) must be prescribed by a Kaiser Permanente physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Kaiser Permanente. External prosthetic devices must meet all of the following criteria: 1) are affixed to the body externally, 2) are required to replace all or part of any body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ, 3) were in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, and 4) are not excluded from coverage from Medicare, and if covered by Medicare, meet the coverage definitions criteria and guidelines established by Medicare at the time the prosthetic is prescribed. Fitting and adjustment of these devices, including repairs and replacement other than due to misuse or loss, is included in coverage. Covered **braces** are those rigid and semi-rigid devices which: 1) are required to support a weak or deformed body member, or 2) are required to restrict or eliminate motion in a diseased or injured part of the body, and 3) are not excluded from coverage from Medicare, and if covered by Medicare, meet the coverage definitions, criteria and guidelines established by Medicare at the time the brace is prescribed. The following items are not covered as external prosthetics, but may be covered under another benefit category: 1) pacemakers and other surgically implanted internal prosthetic devices (these are covered under implanted internal prosthetic devices and aids), 2) hearing aids (these are covered under the hearing aid benefit), and 3) corrective lenses and eyeglasses (these are covered under any applicable pediatric vision care service and may also be covered if an Optical Rider is attached). The following items are excluded from coverage: 1) dental prostheses, devices and appliances, 2) non-rigid appliances such as elastic stockings, garter belts, arch supports, non-rigid corsets and similar devices, 3) orthopedic aids such as corrective shoes and shoe inserts, 4) replacement of lost prosthetic devices, 5) repairs, adjustments or replacements due to misuse or loss, 6) experimental or research devices and appliances, 7) external prosthetic devices related to sexual dysfunction, 8) supplies, whether or not related to external prosthetic devices or braces, 9) external prosthetics for comfort and/or convenience, or which are not medical in nature, and 10) disposable supplies for home use such as bandages, gauze, tape, antiseptics, and ace type bandages. Coverage is limited to the standard model of external prosthetic device or brace in accord with Medicare guidelines that adequately meets the medical needs of the member. Convenience and luxury items and features are not covered.
- When covered as a preventive care service (under the Patient Protection and Affordable Care Act), the following types of **female sterilizations** and related items and services are provided: 1) sterilization surgery for women: Trans-abdominal Surgical Sterilization/Surgical Implant; 2) sterilization implant for women: Trans-cervical Surgical Sterilization Implant; 3) pre and post operative visits associated with female sterilization procedures; and 4) Hysterosalpingogram test following sterilization implant procedure.
- General **health education services** include patient education classes which are educational programs directed toward members who have specific diagnosed medical conditions whereby members are taught self-care skills to understand, monitor, manage and/or improve their condition. Examples of conditions include asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary

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disease (COPD), and behavioral health conditions.

- **Hearing aids** must be prescribed by a Kaiser Permanente physician or Kaiser Permanente audiologist and obtained from sources designated by Kaiser Permanente. Coverage is limited to the lowest priced model hearing aid(s). Hearing aid(s) above the lowest priced model will be provided upon payment of the copayment that member would have paid for a lowest priced model hearing aid(s) plus all additional charges for any amount above the lowest priced model hearing aid(s). All other related costs are excluded from coverage, including but not limited to consultation, fitting, rechecks and adjustments for the hearing aid(s).
- Prescription drugs that are self-administered intravenously under the **home IV/infusion** benefit include biological therapeutics, biopharmaceuticals, or intravenous nutrient solutions needed for primary diet. Self-administered injections are covered upon payment of the member cost share for take-home, self-administered prescription drugs.
- Coverage of **hospice care** is supportive and palliative care for a terminally ill member, as directed by a Kaiser Permanente physician. Hospice coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. The member must be certified by a Kaiser Permanente physician as terminally ill at the beginning of each period. (Hospice benefits apply in lieu of any other plan benefits for treatment of terminal illness.) Hospice includes services such as: 1) nursing care (excluding private duty nursing), 2) medical social services, 3) home health aide services, 4) medical supplies, 5) physician services, 6) counseling and coordination of bereavement services, 7) services of volunteers, and 8) physical therapy, occupational therapy, or speech language pathology.
- **Hospital inpatient care** (for acute care registered bed patients) includes services such as: 1) room and board, 2) general nursing care and special duty nursing, 3) physicians' services, 4) surgical procedures, 5) respiratory therapy and radiation therapy, 6) anesthesia, 7) medical supplies, 8) use of operating and recovery rooms, 9) intensive care room, 10) isolation care room, 11) medically necessary services provided in an intermediate care unit at an acute care facility, 12) special diet, 13) laboratory services, 14) imaging services, 15) testing services, 16) radiation therapy, 17) chemotherapy, 18) physical therapy, 19) occupational therapy, 20) speech therapy, 21) administered drugs, 22) internal prosthetics and devices, 23) blood, 24) durable medical equipment ordinarily furnished by a hospital, and 25) external prosthetic devices and braces ordinarily furnished by a hospital.
- Specialty **imaging services** are services such as CT, interventional radiology, MRI, nuclear medicine, and ultrasound. General radiology includes services such as x-rays and diagnostic mammography.
- Coverage of **in vitro fertilization** is limited to a one-time only benefit at Kaiser Permanente. Please see Coverage Exclusions above for services and items not covered.
- **Internal prosthetics, devices, and aids** (such as pacemakers, hip joints, surgical mesh, stents, bone cement, bolts, screws, and rods) must be prescribed by a Physician, preauthorized in writing by Kaiser Permanente, and obtained from sources designated by Health Plan. Internal prosthetics, devices, and aids are those which meet all of the following: 1) are required to replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ, 2) are used consistently with accepted medical practice and approved for general use by the Federal Food and Drug Administration (FDA), 3) were in general use on March 1 of the year immediately preceding the year in which this Service Agreement became effective or was last renewed, and 4) are not excluded from coverage from Medicare, and if covered by Medicare, meet the coverage definitions, criteria and guidelines established by Medicare at the time the device is prescribed. Fitting and adjustment of these devices, including repairs and replacement other than due to misuse or loss, is included in coverage. The following are excluded from coverage: a) all implanted internal prosthetics and devices and internally implanted aids related to an excluded or non-covered service/benefit, and b) Prosthetics, devices, and aids related to sexual dysfunction. Coverage is limited to the standard prosthetic model that adequately meets the medical needs of the member. Convenience and luxury items and features are not covered.
- The following **interrupted pregnancies** are included: 1) medically indicated abortions, and 2) elective abortions (including abortion drugs such as (RU-486). Elective abortions are limited to two per member per lifetime.
- Specialty **laboratory services** include tissue samples, cell studies, chromosome studies, pathology, and testing for genetic diseases. Basic **laboratory services** include services such as thyroid tests, throat cultures, urine analysis, fasting blood sugar and A1c for diabetes monitoring, electrolytes, drug screening, blood type and cross match, cholesterol tests, and hepatitis B.
- A service or item is **Medically Necessary** (subject to the applicable state law definitions and criteria) only if, 1) recommended by the treating Physician or treating Kaiser Permanente licensed health care practitioner, 2) is approved by Kaiser Permanente's medical director or designee, and 3) is for the purpose of treating a medical condition, is the most appropriate delivery or level of service (considering potential benefits and harms to the patient), and known to be effective in improving health outcomes. Effectiveness is determined first by scientific evidence. If no scientific evidence exists, then by professional standards of care. If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion.
- **Mental health services** include coverage in a specialized mental health treatment unit or facility approved by Kaiser Permanente Medical Group. Specialized mental health treatment services include day treatment or partial hospitalization services and non-hospital residential services. All covered mental health services will be provided under an approved individualized treatment plan.
- **Office visits** are limited to one or more of the following services: examination, history, medical decision making and/or consultation. Members' choice of primary care providers and access to specialty care allow for the following: 1) member may

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choose any primary care physician available to accept member, 2) parents may choose a pediatrician as the primary care physician for their child, 3) members do not need a referral or prior authorization for certain specialty care, such as obstetrical or gynecological care, and 4) the physician may have to get prior authorization for certain services. A **Specialist** is a licensed medical practitioner identified by Health Plan or Medical Group, including a Kaiser Permanente physician, except does not include (i) family practice, (ii) general practice, (iii) internal medicine, (iv) pediatrics, (v) obstetrics/gynecology (including certified nurse midwives), (vi) physician assistants (PA), and (vii) Health Plan employed providers. Members must obtain a referral for most initial visits in order to receive covered services from certain Specialists.

- **Orthodontic services for treatment of orofacial anomalies** resulting from birth defects or birth defect syndromes are limited to Members under 26 years of age, and to a maximum benefit per treatment phase set annually by the insurance commissioner for the applicable calendar year. For example, for 2016 contracts, Member will be responsible for all charges after Health Plan has paid the maximum benefit of \$5,500 per treatment phase.
- Short-term **physical, occupational and speech therapy** (only if the condition is subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply) services means medical services provided for those conditions which meet all of the following criteria: 1) the therapy is ordered by a Physician under an individual treatment plan; 2) in the judgment of a Physician, the condition is subject to significant, measurable improvement in physical function with short-term therapy; 3) the therapy is provided by or under the supervision of a Physician-designated licensed physical, speech, or occupational therapist, as appropriate.; and 4) as determined by a Physician, the therapy must be necessary to sufficiently restore neurological and/or musculoskeletal function that was lost or impaired due to an illness or injury. **Occupational therapy** is limited to hand rehabilitation services, and medical services to achieve improved self care and other customary activities of daily living. **Speech-language pathology** is limited to deficits due to trauma, drug exposure, chronic ear infections, hearing loss, and impairments of specific organic origin.
- **Radiation therapy** services include radium therapy, radioactive isotope therapy, specialty imaging and skilled administered drugs.
- In accordance with **routine obstetrical (maternity) care**, if member is discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), the member's Kaiser Permanente physician may order a follow-up visit for the member and newborn to take place within 48 hours after discharge.
- Covered **skilled nursing care** in an approved facility (such as a hospital or skilled nursing facility) includes the following services: 1) nursing care, 2) room and board (including semi-private rooms), 3) medical social services, 4) medical supplies, 5) durable medical equipment ordinarily provided by a skilled nursing facility, 6) external prosthetic devices and braces ordinarily furnished by a skilled nursing facility, 7) radiation therapy, and 8) chemotherapy. In addition to Health Plan criteria, Medicare guidelines are used to determine when skilled nursing services are covered, except that a prior three-day stay in an acute care hospital is not required.
- Services covered under the **dependent child coverage outside the service area** benefit are subject to the following limitations: 1) services can only be obtained outside Kaiser Permanente Hawaii's service area and outside all other Kaiser Permanente's service areas, at non-Kaiser Permanente facilities and with non-Kaiser Permanente health care providers, 2) the dependent child must pay for services at the point in time the services are received then file a claim for reimbursement by submitting the claim to Kaiser Permanente's claims department, 3) this dependent child coverage benefit cannot be combined with any other benefit, 4) Kaiser Permanente will not pay under this dependent child coverage benefit for a service Kaiser Permanente is covering under another section, such as emergency services, out of area urgent care, and referrals, and 5) this dependent child coverage benefit does not apply to Senior Advantage members and Medicare members with Medicare as primary coverage. The following are excluded under the dependent child coverage outside the service area benefit: 1) transplant services and related care, 2) services received outside the United States, 3) services other than routine primary care, basic laboratory services, basic imaging services, testing services, and self-administered prescription drugs, 4) outpatient surgery and procedures performed in an ambulatory surgery center or other hospital-based setting, 5) services received in other Kaiser Permanente regions' service areas, 6) services received within Kaiser Permanente Hawaii's service area, 7) dental, 8) mail order drugs, 9) chiropractic, acupuncture and massage therapy services, and 10) services not explicitly listed as covered under this dependent child coverage benefit.
- Your incurred copays and coinsurance for covered medical Basic Health Services are capped each calendar year by a medical **supplemental charges maximum**.
 - All incurred copays, coinsurance, and deductibles (if applicable) count toward the limit on supplemental charges, and are credited toward the calendar year in which the medical services were received.
 - Supplemental charges for the following Basic Health Services can be applied toward the supplemental charges maximum, if the item or service is covered under this Service Agreement: office visits for services listed in this Basic Health Services section, allergy test materials, ambulance service, artificial insemination, blood or blood processing, braces, chemical dependency services, contraceptive drugs and devices, payments toward any applicable deductible, diabetes supplies and equipment, dialysis, drugs requiring skilled administration, durable medical equipment, emergency service, external prosthetics, family planning office visits, health evaluation office visits for adults, hearing aids, home health, hospice, imaging (including X-rays), immunizations (excluding travel immunizations), internal prosthetics, internal devices and aids, in vitro fertilization procedure, infertility office visits, inpatient room (semi-private), interrupted pregnancy/abortion, laboratory, medical foods, mental health services, obstetrical (maternity) care, outpatient surgery and procedures, radiation and respiratory therapy, radioactive materials, reconstructive surgery, covered

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self-administered/outpatient prescription drugs (including payments toward any applicable prescription drug deductible), short-term physical therapy, short-term speech therapy, short-term occupational therapy, skilled nursing care, testing services, transplants (the procedure), and urgent care.

- The following services are **not** Basic Health Services and charges for these services/items are not applicable towards the Supplemental Charges Maximum: all services for which coverage has been exhausted, all excluded or non-covered benefits, all other services not specifically listed above as a Basic Health Service, complementary alternative medicine (chiropractic, acupuncture, massage therapy, or naturopathy), dental services, dressings and casts, handling fee or taxes, health education services, classes or support groups, medical social services, office visits for services which are not Basic Health Services, dependent child coverage outside the service area, take-home supplies, and travel immunizations.
- **Testing services** include electrocardiograms, electroencephalograms, EMG, pulmonary function studies, sleep studies, and treadmill.
- Up to a 30-consecutive-day supply of **tobacco cessation drugs and products** is provided when all of the following criteria are met: 1) prescribed by a licensed Prescriber, 2) available on the Health Plan formulary's Tobacco Cessation list of approved drugs and products, including over-the-counter drugs and products, and in accordance with formulary criteria, guidelines, or restrictions, 3) obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital, Kaiser Foundation Health Plan, Inc. or a pharmacy we designate, and 4) member meets Health Plan-approved program-defined requirements for smoking cessation classes or counseling (tobacco cessation classes and counseling sessions are provided at no charge).
- **Tuberculin skin test** is limited to one per calendar year, unless medically necessary.
- **Transplant services** and **transplant evaluations** for transplant donors. Covered transplants include kidney, pancreas, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel, small bowel-liver transplants, small bowel and multivisceral transplants, and stem-cell transplants. Health Plan will pay for medical services for living organ and tissue donors and prospective donors if the medical services meet all of the requirements below. Health Plan pays for these medical services as a courtesy to donors and prospective donors, and this document does not give donors or prospective donors any of the rights of Kaiser Permanente members.
 - Regardless whether the donor is a Kaiser Permanente member or not, the terms, conditions, and Supplemental Charges of the transplant-recipient Kaiser Permanente member will apply. Supplemental charges for medical services provided to transplant donors are the responsibility of the transplant-recipient Kaiser Permanente member to pay, and count toward the transplant-recipient Kaiser Permanente member's limit on supplemental charges.
 - The medical services required are directly related to a covered transplant for a Kaiser Permanente member and required for a) screening of potential donors, b) harvesting the organ or tissue, or c) treatment of complications resulting from the donation.
 - For medical services to treat complications, the donor receives the medical services from Kaiser Permanente practitioners inside a Health Plan Region or Group Health service area.
 - Health Plan will pay for emergency services directly related to the covered transplant that a donor receives from non-Kaiser Permanente practitioners to treat complications.
 - The medical services are provided not later than three months after donation.
 - The medical services are provided while the transplant-recipient is still a Kaiser Permanente member, except that this limitation will not apply if the Kaiser Permanente member's membership terminates because he or she dies.
 - Health Plan will not pay for travel or lodging for donors or prospective donors.
 - Health Plan will not pay for medical services if the donor or prospective donor is not a Kaiser Permanente member and is a member under another health insurance plan, or has access to other sources of payment.
 - The above policy does not apply to blood donors.
- **Urgent care services** are covered for initial urgent care treatment only. "Urgent Care Services" means medically necessary services for a condition that requires prompt medical attention but is not an Emergency Medical Condition. Continuing or follow-up treatment at a non-Kaiser Permanente facility is not covered.

Third party liability, motor vehicle accidents, and surrogacy health services

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. Kaiser Permanente has the right to recover the cost of care for Surrogacy Health Services. Surrogacy Health Services are Services the member receives related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement. The member must reimburse Kaiser Permanente for the costs of Surrogacy Health Services, out of the compensation the member or the member's payee are entitled to receive under the Surrogacy Arrangement.

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	Benefits	You pay
Domestic partner coverage	<p>A Domestic Partner who meets the Domestic Partner eligibility requirements may enroll as a Subscriber's Family Dependent.</p> <p>The Subscriber and Subscriber's Domestic Partner must fill out a Domestic Partner Affidavit and return it to Kaiser Permanente. This information is subject to prior verification by Kaiser Permanente.</p>	

	Benefits	You pay
Drug Rider \$10	<p>For each prescription, when the quantity does not exceed:</p> <ul style="list-style-type: none"> • a 30–consecutive-day supply of a prescribed drug, or • an amount as determined by the formulary. 	\$10 per prescription

Self-administered drugs are covered only when all of the following criteria are met:

- prescribed by a Kaiser Permanente physician/licensed prescriber, or a prescriber we designate,
- on the Health Plan formulary. Senior Advantage members with Medicare Part D are entitled to drugs on the Health Plan formulary and Kaiser Permanente Hawaii Medicare Drug Formulary. Drugs must be used in accordance with formulary guidelines or restrictions,
- the drug is one for which a prescription is required by law,
- obtained at pharmacies in the Service Area that are operated by Kaiser Foundation Hospital or Kaiser Foundation Health Plan, Inc., or pharmacies we designate, and
- drug does not require administration by nor observation by medical personnel.

Insulin		\$10 per prescription
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Diabetes supplies are described in the prescribed drugs section.

Exclusions:

- Drugs for which a prescription is not required by law (e.g. over-the-counter drugs) including condoms, contraceptive foams and creams or other non-prescription substances used individually or in conjunction with any other prescribed drug or device. This exclusion does not apply to tobacco cessation drugs and products as described in the prescribed drugs section.
- Drugs and their associated dosage strengths and forms in the same therapeutic category

as a non-prescription drug that have the same indication as the non-prescription drug.

- Drugs obtained from a non-Kaiser Permanente pharmacy.
- Non-prescription vitamins.
- Drugs when used primarily for cosmetic purposes.
- Medical supplies such as dressings and antiseptics.
- Reusable devices such as blood glucose monitors and lancet cartridges.
- Diabetes supplies such as blood glucose test strips, lancets, syringes and needles.
- Non-formulary drugs unless specifically prescribed and authorized by a Kaiser Permanente physician/licensed prescriber, or prescriber we designate.
- Brand-name/specialty drugs requested by a Member when there is a generic equivalent.
- Prescribed drugs that are necessary for or associated with excluded or non-covered services, except for Senior Advantage Members with Medicare Part D.
- Drugs related to sexual dysfunction.
- Drugs to shorten the duration of the common cold.
- Drugs related to enhancing athletic performance (such as weight training and body building).
- Any packaging other than the dispensing pharmacy's standard packaging.
- Immunizations, including travel immunizations.
- Contraceptive drugs and devices (to prevent unwanted pregnancies).
- Abortion drugs (such as RU-486).

Replacement of lost, stolen or damaged drugs.

Questions and answers about the drug rider

1. *How does the drug rider work?*

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

- In most cases you will be charged only \$3 for a generic Maintenance drug prescription, \$10 each for all other generic drug prescriptions, \$45 for a brand-name drug prescription, and \$200 for a Specialty drug prescription when it does not exceed a 30-consecutive-day supply of a prescribed drug (or an amount as determined by the formulary). Each refill of the same prescription will also be provided at the same charge.
- If you go to a non-Kaiser Permanente pharmacy, you will be responsible for 100% of charges.

2. *Where are Kaiser Permanente pharmacies located?*

Most Kaiser Permanente Clinics have a pharmacy on premises. Please consult the Member Handbook for the pharmacy nearest you and its hours of operation.

3. *Can I get any drug prescribed by my Physician?*

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

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

4. *Do I need to present any identification when I receive drugs?*

Yes, always present your Kaiser Permanente membership ID card, which has your medical record number, to the pharmacist. If you do not have a medical record number, please call Member Services at 1-800-966-5955.

5. *What if I need more than a month's supply of medication?*

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

6. *How do I receive prescriptions by mail?*

Save time and money on refills! If you have prescription drug coverage, you can get a 90-day supply of qualified prescription drugs covered under your drug rider for the price of 60 by using our convenient mail order service*. And we pay the postage!

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

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

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

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

*We are not licensed to mail medications out of state. There are restrictions for delivery of certain medications and supplies, including but not limited to controlled medications, injections, medications affected by temperature, and medications excluded by Kaiser Permanente's Pharmacy & Therapeutic Committee.

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

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

	Benefits	You pay
Hearing Aids rider - 60%	Up to two medically necessary and appropriate hearing aids , one for each hearing impaired ear, once every 36 months when prescribed by a KP physician or KP audiologist, and obtained from sources designated by Health Plan	60% of applicable charges per ear, once every three years

Limitations:

- Coverage is limited to the lowest priced model hearing aid in accordance with Kaiser’s guidelines that adequately meets the medical needs of the Member.
- Hearing aids above the lowest priced model will be provided upon payment of the applicable charges that the Member would have paid for a lowest priced model hearing aid plus all additional charges for any amount above the lowest priced model hearing aid.

Exclusions:

- All other hearing aid related costs, including but not limited to: consultation, fitting, rechecks and adjustments for the hearing aid(s).

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 free 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.

Hawaii	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.

አማርኛ (Amharic): ያለምንም ክፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኬሲር ፐርማኒንቴ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የስልክ ቁጥር ለስቴትዎ ወይም ለክልልዎ ደውለው ከአስተርጓሚ ጋር ይነጋገሩ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو إذا كان هذا الإشعار الذي يتطلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր դիմումի կամ Kaiser Permanente-ի վիզոցով Ձեր ծածկույթի վերաբերյալ, կամ եթե սա ծանուցում է, որը պարտադրում է Ձեզ, որպեսզի գործուղություններ ձեռնարկեք մինչև որոշակի ամսաթիվ, սպաս զանգահարեք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Bàsòò Wùdù (Bassa): Ɔ mò nì kpé bé ì ké gbo-kpá-kpá dyé dé nì miòùn niìn bídí-wùdù mú pídyi. Ɔ jũ ké ì dyi dyi-diè-dè bé bédé bá nì céè-dè ì tò bó dè zò jè dyíé ní, mɔɔ jũ bá nì kùùn kpɔ́ jè dyí dyiìn dé Kaiser Permanente múé ní, mɔɔ ɔ dyi bɔ́ dò jũ bé ì ké dè dò nyu bó wé jéé dò kɔ́ nì, níí, dá nòbà bé wa tòà bó nì bóódò mɔɔ nì gbèèò biìe, ké nì mu nyo-wuɖuún-zà-nyò dò gbo wùdùùn.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার যদি আপনার আবেদন বা Kaiser Permanente-এর মাধ্যমে পাওয়া কভারেজ নিয়ে কোনো প্রশ্ন থাকে বা এটি যদি কোনো নোটিস হয় যার ফলে আপনার একটি নির্ধারিত দিনের মধ্যে কোনো পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সাথে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

California	1-800-464-4000
Colorado	1-800-632-9700
District of Columbia	1-800-777-7902
Georgia	1-888-865-5813
Hawaii	1-800-966-5955
Maryland	1-800-777-7902
Oregon	1-800-813-2000
Virginia	1-800-777-7902
Washington	1-800-813-2000
TTY	711

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

Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo aplikasyon o coverage sa Kaiser Permanente, o kung kining pahibalo nanginahanglan sa inyo paglihok sa dili pa usa ka pihon nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者如果本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chukese): Mei wor omw pwuung omw kopwe angei aninis non foosun fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw apilikeison me/ika policy fan nemenien Kaiser Permanente, are ika ei esinesin a erenuk pwe kopwe fori pwan ekoch foror, ka tongeni omw kopwe kori ewe nampa mei kawor faniten omw state ika fonu (asan) iwe eman chon chiakku epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઈ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને Kaiser Permanente મારફતે તમારી અરજી અથવા કવરેજ વિશે પ્રશ્નો હોય, અથવા જો આ નોટિસ હોય જેમાં તમને કોઈ ચોક્કસ તારીખથી પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પૂરા પાડવામાં આવેલ નંબર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avi sa a gen bagay ou sipoze fè sa a avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

‘ōlelo Hawai‘i (Hawaiian): He pono a ua loa‘a no kekahi kōkua me kāu ‘ōlelo inā makemake a he manuahi no ho‘i. Inā he mau nīnau kāu e pili ana i kāu palapala noi ‘inikua ola kino a i ‘ole i kōkua ma‘ō ka polokalamu kōkua ola kino Kaiser Permanente, a i ‘ole inā ke ha‘i nei paha kēia leka nei iā‘oe e hana koke aku i kēia ma mua o kekahi lā i waiho ‘ia, e kelepona aku i ka helu i loa‘a ma kēia leka nei no kāu moku‘āina a i ‘ole pana‘āina no ka wala‘au ‘ana me kekahi kanaka unuhi ‘ōlelo.

हिन्दी (Hindi): आपको बिना किसी कीमत चुकाए आपकी भाषा में सहायता पाने का अधिकार है। यदि आप आपके आवेदन पत्र के विषय में या Kaiser Permanente के कवरेज के विषय में कुछ पूछना चाहते हैं या यदि यह एक नोटिस है जिसके कारण आपको किसी विशेष तिथि तक कारवाई करनी पड़ेगी तो आपके राज्य या क्षेत्र के लिए दिए गए नंबर पर फोन करके किसी दुभाषिये से बात करें।

Hmoob (Hmong): Koj muaj cai kom tau txais kev pab uas hais koj hom lus yam tsis tau them nqi. Yog koj muaj lus nug txog koj daim ntawv thov los yog cov kev pab them nyiaj tim Kaiser Permanente, los yog tias daim ntawv no yog ib tsab ntawv ceebtoom uas yuav kom koj ua ib yam dabtsi raws li hnuv tau teev tseg, hu rau tus nab npawb xovtooj uas tau muab rau koj lub xeev lossis cheeb tsam kom tau tham nrog tus kws txhais lus.

Igbo (Igbo): ! nwere ikike inweta enyemaka n'asusụ gi na akwughị ugwo ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara akwụkwọ anamachoihe gi ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ ọ bụrụ na nke bụ ọkwa a chọrọ ka ị mee ihe tupu otu ụbọchi, kpọọ nomba enyere maka steeti ma ọ bụ mpaghara gi iji kwukọrịta okwu n'etiti onye ọkọwa okwu.

Iloko (Ilocano): Adda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep ti aplikasionyo wenno coverage babaen ti Kaiser Permanente, wenno no daytoy ket maysa a pakdaar a kalikagumanna a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehiyon tapno makipatang ti maysa mangipatarus iti pagsasao.

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、あなたが特定の日付までに行動を起こすよう依頼されている場合、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。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីពាក្យស្នើសុំប្រការធានារ៉ាប់រងតាមរយៈ Kaiser Permanente ឬប្រសិនបើជាលិខិតជូនដំណឹងដែលតម្រូវឱ្យអ្នកចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ។

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 조취를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຽຄ່າ. ຖ້າວ່າ ທ່ານມີຄໍາຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງຜ່ານ Kaiser Permanente, ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດໍາເນີນການພາຍໃນວັນທີ່ທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດ ຫຼື ເຂດຂອງທ່ານ ເພື່ອຂໍລິມັດຖານພາສາ.

Kajin Majōl (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjelōk wōṇāān. Ñe ewōr aṃ kajitōk kōn peba in aplaiki eo aṃ ak insurance eo aṃ jān Kaiser Permanente, ak ñe enaan in kōjelā in ej aikuj bwe kwōn ṃakūtūt ṃokta jān juon raan eo eṃōj an kallikkar, kaḷok nōṃba eo ej leḷok ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): T’áá ni nizaad bee níká i’ doolwoł doo bik’ é asíníááagóó éí bee náhaz’á. Kaiser Permanente áká aná’álwo’ ná bik’ é azláadoo yíníkeedgo naaltsoos hadinílaa, éí bína’ídílkid doogo, éí doodago díí naaltsoos haa’ída yookkáalgo hait’áoda í’díííííí níṃniigo éí nitsaa hahoodzojí éí doodago t’áá aadi nahós’a’di ata’ dahalne’ígíí bich’í’ hólne’go bee bíł ahił hodíílnih.

नेपाली (Nepali): तपाईंसगं कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसगं आफ्नो आवेदन बारे वा Kaiser Permanente माफत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्बरमा कल गर्नुहोस् ।

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 fudhattu gaafatu ta’e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سوالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng aplikeisin de iren audepe kan ohng Kaiser Permanente, de ma pakair wet me anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr ohng owmi palien wehi pwe komwi en lokaiaien 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.

ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਮੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੀ ਅਰਜ਼ੀ ਜਾਂ Kaiser Permanente ਰਾਹੀਂ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਇਸ ਨੋਟਿਸ ਵਜੋਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ.

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de solicitarea dumneavoastră sau de acoperirea oferită de Kaiser Permanente sau dacă acest aviz vă solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо если такое уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou 'aia e maua se fesoasoani i lou gagana e aunoa ma le totogi. Afai e iai ni fesili e uiga i lou tusi apalai po o puipuiga e ala mai Kaiser Permanente, po o lenei tusi e manaomia ona e gaoioi i se taimi atofaina, vili le numera ua fuafuaina mo lou setete po o oganuu e fesoata'i i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o si este es un aviso que requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o kung ito ay abisong nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับการสมัครของท่าน หรือความคุ้มครองผ่าน Kaiser Permanente หรือหากนี่คือหนังสือที่ต้องการให้ท่านดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): 'Oku 'ia ho totonu ke ke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'o fehu'i ki ho tohi kole na'e fakafonu ki he malu'i 'inisiua 'a e Kaiser Permanente, pea kapau ko e tohina 'oku fiema'u keke fai ha me'a ki ai pe ko ha 'aho na'e tuku pau atu ke fai ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua 'oku ke 'i ai ke talanoa mo ha tokotaha tene fakatonu lea atu kiate koe.

Українська (Ukrainian): У Вас є право на отримання допомоги безкоштовно на Вашій рідній мові. Якщо Ви маєте питання стосовно Вашого звернення чи страхового покриття в Kaiser Permanente, чи якщо відповідно до такого повідомлення Вам треба буде здійснити певну дію до конкретної дати, подзвоніть по номеру, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اردو (Urdu): آپ کو کوئی بھی قیمت ادا کرنے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنی درخواست یا Kaiser Permanente کے ذریعہ کوریج کے متعلق کوئی بھی سوالات ہیں، یا اگر اس نوٹس کی وجہ سے آپ کو کسی مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہوگی تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc đây là thông báo yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ètò ò láti rí irànlọwọ gbà nípa èdè rẹ láisan owó. Bí o bá ní ibèèrè nípa iwé tí o kọ tàbí ìṣedéédé nípaṣẹ Kaiser Permanente, tàbí ifitonilétí yíi jẹ èyí o nilò láti igbésẹ kan ní ojọ kan patọ, pé nọmbà tí a pèsè fún ipínlẹ tàbí agbègbè rẹ láti bá òngbifọ kan sọrọ.