Kaiser Foundation Health Plan, Inc.

Kaiser Permanente Hawaii's Guide to Your Health Plan

Kaiser Permanente Group Plan

January 2026

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Benefit and Payment Chart

About this Chart

This benefit and payment chart:

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

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

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

If a benefit in the Benefit and Payment Chart is not listed, or is listed as "Not covered" the descriptions related to that benefit in Chapter 1, 3, and 4 are not applicable.

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

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

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

Description	Page #	Cost Share
Annual Copayment Maximum		
Member	13	$2,500 per calendar year
Family Unit	13	$7,500 per calendar year (for 3 or more members)
Annual Deductible		
Member	14	None
Family Unit	14	None
Routine and Preventive		
Health Education and Disease Management		
• Medical Office Visits		
o Primary Care	18	$15 per visit
o Specialty Care	18	$15 per visit
• Tobacco Cessation and Counseling Sessions	18	None
• Health education publications	18	None
• Healthy Living Classes	18	Applicable class fees
Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))	18	None
• Office Visit for (CDC) Immunizations	19	None
• Office visit for Travel Immunization		
o Primary Care	19	$15 per visit
o Specialty Care	19	$15 per visit
Medical Office Visits		
• Well-Child Care	19	None
• Annual Preventive Care (physical exam)	19	None
• Hearing Exam (for correction)		
o Primary Care	19	$15 per visit
o Specialty Care	19	$15 per visit

Description	Page #	Cost Share
• Vision Exam (for glasses)		
o Primary Care	19	$15 per visit
o Specialty Care	19	$15 per visit
Preventive Screenings and Care	20	None
Total Health Assessment (www.kp.org)	21	None
Special Services for Women		
Preventive Care		
• Annual Gynecological Exam	21	None
• Mammography (screening)	21	None
• Pap Smears (cervical cancer screening)	21	None
Family Planning Visits		
• Primary Care	21	$15 per visit
• Specialty Care	21	$15 per visit
Infertility Consultation		
• Primary Care	21	$15 per visit
• Specialty Care	21	$15 per visit
In Vitro Fertilization	22	20% of Applicable Charges
Maternity		
• Maternity Care – routine prenatal visits and postpartum visits in Medical Office	23	None
• Maternity Care – delivery	23	None
• Maternity Care –postpartum visits in Medical Office	23	None
• Maternity and Newborn Inpatient Stay	23	None
• Breast Pump	23	None
Pregnancy Termination		
• Primary Care	23	$15 per visit

Description	Page #	Cost Share
• Specialty Care	23	$15 per visit
• Total Care Settings	30	Included in Total Care Services
Voluntary sterilization (including tubal ligation)		
• Medical Office	24	None
• Total Care Settings	30	None
Special Services for Men		
Vasectomy		
• Primary Care	24	$15 per visit
• Specialty Care	24	$15 per visit
• Total Care Settings	30	Included in Total Care Services
Online Care		
My Health Manager (www.kp.org)	24	None
Medical Office Visits		
Medical Office Visits		
• Primary Care	24	$15 per visit
• Specialty Care	24	$15 per visit
• Routine pre-surgical and post-surgical	24	None
Urgent Care Visits		
• Within Service Area	25	$15 per visit
• Outside Service Area	25	20% of Applicable Charges
Dependent Child Outside of Service Area		
• Outpatient care	25	$20 per visit for the first 10 visits, and 50% of Applicable Charges for additional visits
• Basic laboratory and general imaging	25	$10 per visit for the first 10 visits (combined total for laboratory, imaging and testing), and 50% of Applicable Charges for additional visits

Description	Page #	Cost Share
• Testing	25	20% of Applicable Charges for the first 10 visits (combined total for laboratory, imaging and testing), and 50% of Applicable Charges for additional visits
• Immunizations	25	None
• Contraceptive drugs and devices	25	None
• Self-administered drug prescriptions	25	20% of Applicable Charges for the first 10 prescriptions, and 50% of Applicable Charges for additional prescriptions
House Calls		
• Primary Care	26	$15 per visit
• Specialty Care	26	$15 per visit
Telehealth	26	Cost Share, if applicable, will vary depending on Service

Laboratory, Imaging, and Testing

Laboratory		
• Basic	26	$15 per day
• Specialty	26	20% of Applicable Charges
Imaging		
• General	27	$15 per day
• Specialty	27	20% of Applicable Charges
Testing		
• Allergy Testing		
o Primary Care	28	$15 per visit
o Specialty Care	28	$15 per visit
• Skilled-Administered Drugs	28	20% of Applicable Charges

Description	Page #	Cost Share
• Diagnostic Testing	28	20% of Applicable Charges

Surgery

Outpatient Surgery and Procedures		
• Primary Care	28	$15 per visit
• Specialty Care	28	$15 per visit
• Total Care Settings	30	Included in Total Care Services
Reconstructive Surgery		
• Primary Care	29	$15 per visit
• Specialty Care	29	$15 per visit
• Covered Mastectomy	29	10% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services

Total Care Services

You may only pay a single Cost Share for covered benefits you receive in Total Care Service settings. Here are examples:

Inpatient Hospital Services	30	10% of Applicable Charges
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	30	10% of Applicable Charges
Emergency Services	31	$100 per visit (in- and out-of-area)
Observation	35	None
Skilled Nursing Facility	35	10% of Applicable Charges for up to 120 days per calendar year
Dialysis		
• Dialysis	35	20% of Applicable Charges
• Equipment, Training and Medical Supplies for home Dialysis	35	None
Radiation Therapy	35	20% of Applicable Charges

Ambulance

Air Ambulance	36	20% of Applicable Charges

Description	Page #	Cost Share
Ground Ambulance	36	20% of Applicable Charges
Physical, Occupational, and Speech Therapy		
Physical and Occupational Therapy		
• Medical Office	37	$15 per visit
• Home Health Care	37	None
• Total Care Settings	30	Included in Total Care Services
Speech Therapy		
• Medical Office	37	$15 per visit
• Home Health Care	37	None
• Total Care Settings	30	Included in Total Care Services
Home Health Care and Hospice Care		
Home Health Care	38	None
Hospice Care	38	None
Physician Visits		
• Primary Care	39	$15 per visit
• Specialty Care	39	$15 per visit
Chemotherapy Services		
• Primary Care	39	$15 per visit
• Specialty Care	39	$15 per visit
• Total Care Settings	30	Included in Total Care Services
Internal, External Prosthetics Devices and Braces		
Implanted Internal Prosthetics, Devices and Aids		
• Medical Office	39	None
• Total Care Settings	30	Included in Total Care Services
External Prosthetics Devices		
• Outpatient	40	20% of Applicable Charges

Description	Page #	Cost Share
• Total Care Settings	30	Included in Total Care Services
Braces		
• Outpatient	40	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services

Durable Medical Equipment

Durable Medical Equipment		
• Outpatient	41	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Oxygen (for use with DME)		
• Outpatient	41	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Repair or Replacement		
• Outpatient	41	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Diabetes Equipment	42	50% of Applicable Charges
Home Phototherapy Equipment	42	None

Behavioral Health – Mental Health and Substance Abuse

Mental Health Care		
• Medical Office	42	$15 per visit
• Total Care Settings	30	Included in Total Care Services
Chemical Dependency Care		
• Medical Office	43	$15 per visit
• Total Care Settings	30	Included in Total Care Services
Autism Care		
• Primary Care	43	$15 per visit

Description	Page #	Cost Share
• Specialty Care	43	$15 per visit
Transplants		
Transplant Care for Transplant Recipients		
• Primary Care	43	$15 per visit
• Specialty Care	43	$15 per visit
• Total Care Settings	30	Included in Total Care Services
Transplant Services for Transplant Donors (based on health plan approval)		
• Primary Care	44	$15 per visit
• Specialty Care	44	$15 per visit
• Total Care Settings	30	Included in Total Care Services
Related Prescription Drugs	45	See prescription drugs in this *Benefit Summary*
Transplant Evaluations		
• Primary Care	45	$15 per visit
• Specialty Care	45	$15 per visit
Prescription Drug		
Skilled Administered Drugs	45	20% of Applicable Charges; Included in Total Care Services
Self-Administered Drugs	46	If your employer has purchased a drug rider, coverage will be as specified in your drug rider following this *Benefit Summary*
Chemotherapy Drugs		
• Chemotherapy Infusion or Injections (Skilled Administered Drugs)	46	20% of Applicable Charges

Description	Page #	Cost Share
• Chemotherapy – Oral Drugs (Self-Administered Drugs)	46	20% of Applicable Charges; or as specified in applicable drug rider
Contraceptive Drugs and Devices	46	50% of Applicable Charges or None
Diabetic Supplies	47	50% of Applicable Charges
Tobacco Cessation Drugs and Products	47	None (up to 30-day supply)
Drug Therapy Care		
Growth Hormone Therapy		
• Primary Care	47	$15 per visit
• Specialty Care	47	$15 per visit
• Skilled-Administered Drug	45	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Home IV/Infusion therapy		
• Therapy and IV drugs	48	None
• Self-administered injections	48	See prescription drugs in this *Benefit Summary*
Inhalation Therapy		
• Primary Care	48	$15 per visit
• Specialty Care	48	$15 per visit
• Total Care Settings	30	Included in Total Care Services
Miscellaneous Medical Treatments		
Blood and Blood Products		
• Medical Office	49	None
• Rh Immune Globulin	45	20% of Applicable Charges
• Total Care Settings	30	Included in Total Care Services
Dental Procedures for Children		
• Primary Care	49	$15 per visit
• Specialty Care	49	$15 per visit
• Total Care Settings	30	Included in Total Care Services

Description	Page #	Cost Share
Hearing Aids		
• Hearing Test		
o Primary Care	49	$15 per visit
o Specialty Care	49	$15 per visit
• Appliances	49	20% of Applicable Charges
Hyperbaric Oxygen Therapy		
• Primary Care	49	$15 per visit
• Specialty Care	49	$15 per visit
• Total Care Setting	30	Included in Total Care Services
Materials for Dressings and Casts	50	Cost Share will vary upon place of service
• Total Care Setting	30	Included in Total Care Services
Medical Foods	50	20% of Applicable Charges
Medical Social Services	50	None
Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)		
• Primary Care	50	$15 per visit
• Specialty Care	50	$15 per visit
Rehabilitation Services		
• Primary Care	50	$15 per visit
• Specialty Care	50	$15 per visit
• Total Care Setting	30	Included in Total Care Services

rev. 05/2025

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Kaiser Foundation Health Plan, Inc. – Hawaii
Prescription Drug Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

Note: We also cover some outpatient drugs and supplies in the Prescription Drugs section in *Chapter 3: Benefit Description* of this Guide. For Senior Advantage members, we also cover some outpatient drugs and supplies in the Medical Benefits Chart in the front of the EOC and for Part D members, in Chapters 5 and 6. This Rider amends the Kaiser Permanente Senior Advantage Evidence of Coverage (EOC) to include additional coverage for Prescription Drugs. The information in this Rider only applies to the Prescription Drugs covered under this Rider.

Benefit Summary

Description	Cost Share
Self-administered Prescription Drugs (member-purchased outpatient drugs at Kaiser Permanente Pharmacies)	
Generic maintenance drugs *	$3
Other Generic drugs *	$10
Brand-name drugs *	$45
Specialty drugs *	$200
Refills through Mail-Order Program (for up to a 90-consecutive-day supply)	
Generic maintenance drugs	Two times the above-listed copay
Other Generic drugs	Two times the above-listed copay
Brand-name drugs	Two times the above-listed copay
Specialty drugs *	$200
Insulin – other generic	$10
Insulin – brand name	$45
WellRx Program drugs *	Not applicable

* For up to a 30-consecutive-day supply per prescription, or an amount as determined by the Kaiser

Permanente formulary.

Benefit Description

Self-administered Prescription Drugs (member-purchased outpatient drugs at Kaiser Permanente Pharmacies)

Covered Drugs and Supplies
We cover self-administered prescription drugs and supplies only if all of the following conditions are met:

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

Notes: Immunizations are described in *Chapter 3: Benefit Description* under *Routine and Preventive*. Contraceptive drugs and devices are described in *Chapter 3: Benefit Description* under *Routine and Preventive*. Diabetic equipment and supplies are described in *Chapter 3: Benefit Description* under the Durable Medical Equipment (DME) and Prescription Drug. Senior Advantage members, see the Medical Benefits Chart.

Cost Share for Covered Drugs and Supplies
When you get a prescription from a Kaiser Permanente Pharmacy, pharmacy we designate, or order a prescription from our Kaiser Permanente Mail-Order Pharmacy, you pay the Cost Share as shown in the above Benefit Summary. A reasonable charge is made for prescribed quantities in excess of the amounts described in the Benefit Summary. Each refill of the same prescription will also be provided at the same charge.

The Cost Share amounts count toward the Annual Copayment Maximum, or the Annual Prescription Drug Copayment Maximum if you have one listed in the above Benefit Summary. This applies for each covered prescription. Note: For Senior Advantage members, these amounts do not count towards the out-of-pocket maximum. Medicare has rules about what counts and what does not count toward your out-of-pocket costs.

If you get a prescription from a non-Kaiser Permanente pharmacy or non-contracted pharmacy, you will be responsible for 100% of the charges because it is not covered under this Prescription Drug Rider.

Day Supply Limit
The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day

supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-consecutive-day (or any other number of days) supply for you. Dispensing limitations may apply within the 30-consecutive-day supply period for certain drugs. When you pay the Cost Share shown in the Benefit Summary, you will receive the prescribed supply up to the day supply limit.

How to Get Covered Drugs or Supplies
Our pharmacies are located in most Kaiser Permanente clinics. To find a pharmacy, please see your Caring for You: Physicians and Locations Directory, visit www.kp.org, or contact Member Services. You must present your KP membership ID card, which has your medical record number, and a photo ID to the pharmacist.

Our mail-order pharmacy offers postage-paid delivery for refills of Maintenance drugs. Some drugs and supplies are not available through our mail-order pharmacy and/or not eligible for the mail-order cost share. Examples include but are not limited to controlled substances as determined by state and/or federal regulations, bulky items, drugs that require special handling or refrigeration (such as insulin), injectables, and other products and dosage forms as identified by the Kaiser Permanente Pharmacy and Therapeutics Committee. Drugs and supplies available through our mail-order pharmacy are subject to change at any time without notice.

If you would like to use our mail-order pharmacy, use one of the methods below:

- Register and order online securely at www.kp.org/refill
- Use the Kaiser Permanente mobile app
- Call our Mail-order Pharmacy at **(808) 643-7979** (TTY **711**), Monday through Friday, 8 a.m. to 5 p.m.

Definitions
The following terms, when capitalized and used in this Prescription Drug Rider mean:

- ***Brand-name Drug.*** The first U.S. Food and Drug Administration (FDA) approved version of a drug. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent. 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).

- ***Generic Drug.*** A drug that contains the same active ingredient as a Brand-Name Drug and is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent and having the same active ingredient(s) as the Brand-name Drug. Generic Drugs are produced and sold under their Generic names after the patent of the Brand-Name drug expires. Generally, Generic Drugs cost less than Brand-Name Drugs, and must be identical in strength, safety, purity, and effectiveness.

- ***Generic Maintenance Drug.*** A specific Generic Drug to treat chronic conditions and is on Health Plan's approved list. Note: Not all Generic Drugs to treat chronic conditions are considered Generic Maintenance Drugs.

- ***Maintenance Drug.*** A drug to treat chronic conditions, such as asthma, high blood pressure, diabetes, high cholesterol, cardiovascular disease, and mental health.

- ***Specialty Drug.*** A very high-cost drug approved by the U.S. Food and Drug Administration (FDA).

- ***Annual Prescription Drug Copayment Maximum.*** (If not specified in this Benefit Summary, does not apply.) The Annual Prescription Drug Copayment Maximum is the maximum amount for Pharmacy Dispensed Drugs you pay out of your pocket in an Accumulation Period. Once you meet the Annual Prescription Drug Copayment Maximum, you are no longer responsible for Cost Share amounts for covered Pharmacy Dispensed Drugs for the remainder of that Accumulation Period. For Senior Advantage members with Part D, please see Chapter 6 in your Evidence of Coverage.

    - "Pharmacy Dispensed Drugs" include all covered safe to self-administer pharmacy dispensed drugs, including but not limited to inhalers, insulin, chemotherapy drugs, contraceptive drugs/devices, and tobacco cessation drugs.

    - All incurred Cost Share and prescription drug deductibles (if applicable) for Pharmacy Dispensed Drugs count toward the Annual Prescription Drug Copayment Maximum, and are credited toward the Accumulation Period in which they were received.

    - Note: The following medical items count toward the Annual Copayment Maximum and not the Annual Prescription Drug Copayment Maximum: skilled administered drugs, diabetes supplies to operate diabetes equipment, lancets, syringes, and drugs that are not dispensed from the pharmacy because they are not safe to self-administer.

    - Payments made by you or on your behalf for non-covered services, or for benefits excluded under this EOC do not count toward the Annual Copayment Maximum nor the Prescription Drug Copayment Maximum.

    - It is recommended that you keep receipts as proof of your payments. All payments are credited toward the Accumulation Period in which the services were received.

- ***Annual Prescription Drug Deductible.*** (If not specified in this Benefit Summary, does not apply.) The Annual Prescription Drug Deductible is the amount you must pay for certain types of self-administered prescription drugs in an Accumulation Period before we will cover those drugs. Once you meet the Annual Prescription Drug Deductible, you are no longer responsible for prescription drug deductible amounts for the remainder of the Accumulation Period, and you pay the Cost Share shown in the Benefit Summary.

    - Each Member must meet the “per Member” Annual Prescription Drug Deductible, or the Family Unit must meet the “family unit” Annual Drug Deductible.

    - The “per Member” Annual Prescription Drug Deductible amount counts toward the “per family unit” Annual Prescription Drug Deductible amount. Once the “per Member” Annual Prescription Drug Deductible is satisfied, no further Annual Prescription Drug Deductible will be due for that Member for the remainder of the Accumulation Period. Once the “per family unit” Annual Prescription Drug Deductible is satisfied, no further “per Member” Prescription Drug Deductibles will be due for the remainder of the Accumulation Period.

    - The Annual Prescription Drug Deductible is separate from any other deductible that may be described in the Benefit Summary in the front of this Guide. Payments toward the Annual Prescription Drug Deductible do not count toward any other deductible. Consequently, payments toward any other deductible do not count toward the Annual Prescription Drug Deductible.

- Payments toward the Annual Prescription Drug Deductible also count toward the limit on Annual Prescription Drug Copayment Maximum.

- **WellRx Program.** The WellRx Program is a program that meets all of the following criteria:
  - applies to non-Medicare Members who have been identified through Kaiser Permanente's disease registries as eligible for the WellRx Program,
  - these Members may receive their 30-consecutive-day supply of a self-administered chronic disease drug or diabetes supply without charge, and
  - only certain chronic disease drugs identified on the Health Plan formulary are available as part of this program, and the eligible drugs are subject to the same requirements as self-administered drugs.

About Our Drug Formulary
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 non-formulary drugs are generally not covered under your prescription drug Rider, your Kaiser Permanente physician can sometimes request a non-formulary drug for you, specifically when formulary alternatives have failed or use of non-formulary 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 nonformulary drug, you will be charged Member Rates for these selections, since they are not covered under your prescription drug Rider. If your Kaiser Permanente physician deems a higher priced drug to be Medically Necessary when a less expensive drug is available, you pay the usual drug Cost Share. If you request the higher priced drug and it has not been deemed Medically Necessary, you will be charged Member Rates.

Note: If your prescription allows refills, there are limits to how early you can receive a refill. The Kaiser Permanente mobile app and online www.kp.org will let you know when it's time for a prescription refill.

Services Not Covered

- 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 *Chapter 3: Benefit Description* under *Prescription Drugs*.
- Drugs in the same therapeutic category as the non-prescription drug, as approved by the Kaiser Permanente Pharmacy & Therapeutics Committee.
- Drugs obtained from a non-Kaiser Permanente pharmacy or non-contracted pharmacy.
- Non-prescription vitamins.
- Drugs used for weight management.
- 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, except Senior Advantage Members with Medicare Part D covers syringes and needles under this Prescription Drug Rider. Note: Diabetes supplies are covered in *Chapter 3: Benefit Description* under *Diabetic Supplies*.
- 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.
- Drugs not included on the Health Plan formulary, unless a non-formulary drug has been specifically prescribed and authorized by the licensed Prescriber.
- Drugs to shorten the duration of the common cold.
- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Drugs and supplies to treat sexual dysfunction.
- Drugs used to enhance athletic performance (including weight training and body building).
- Replacement of lost, stolen or damaged drugs or supplies.

Kaiser Foundation Health Plan, Inc. – Hawaii
Dental Rider – 1801

This rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this rider.

For Senior Advantage members, this Rider amends the Kaiser Permanente Senior Advantage *Evidence of Coverage* (EOC) to include additional coverage for Dental Care.

The following amends part of *Chapter 4: Services Not Covered:*

Dental Care: You are not covered for dental care Services, except as described in this rider.

All benefits are governed by the provisions of Kaiser Foundation Health Plan, Inc.'s (Kaiser) Agreement with Hawaii Dental Service (herein referred to as "HDS") and HDS's procedure code guidelines. If there are inconsistencies, then the agreement between Kaiser and HDS shall govern. All dental claims must be filed within 12 months of the date of service for HDS claims payment.

A description of the HDS dental benefits covered under this rider was provided to Kaiser Permanente directly from HDS and is on the following page *"Summary of Dental Benefits"*.

DELTA DENTAL

HDS
Hawaii Dental Service

Summary of Dental Benefits
Kaiser Foundation Health Plan - Group No.1801
Effective: 01/01/2026

This summary is a brief description of a Hawaii Dental Service (HDS) member's dental benefits. Some limitations, restrictions, and exclusions may apply. Plan benefits are governed by the provisions detailed in the group's and/or subscriber's agreement with HDS, HDS's Procedure Code Guidelines and Delta Dental National Policies when applicable. Certain provisions may vary across group agreements such as waiting periods, frequency and age limitations, etc. and may not be included in this summary. For additional information, please contact HDS Customer Service. As an HDS member, you may visit any licensed dentist, but your out-of-pocket costs may be lower when visiting an HDS participating dentist. All dental claims must be filed within 12 months of the date of service to be eligible for HDS claims payment.

	ADULTS – AGE 19 & OLDER	CHILDREN – AGE 18 & UNDER
PLAN MAXIMUM $1200 per person per calendar year. The most HDS will pay for each person for all covered dental services performed during the calendar year.	1,200 per yr	N/A
DIAGNOSTIC & PREVENTIVE WAIVER HDS's payment for Diagnostic and Preventive services will not be deducted from the member's Plan Maximum.	Yes	N/A
	HDS PLAN PAYS	
DIAGNOSTIC		
Examinations	100% 2x/yr	100% 2x/yr
Bitewing X-rays	100% 1x/yr	100% 2x/yr
Other X-rays	70% Full mouth X-rays 1x/5 yrs	70% Full mouth X-rays 1x/5 yrs
PREVENTIVE		
Cleanings	100% 2x/yr	100% 2x/yr
Fluoride	Not Covered N/A	100% 2x/yr Through age 18
Silver Diamine Fluoride	100%	100%
Space Maintainers	Not Covered	100% Through age 18
Sealants One treatment per tooth per lifetime to permanent molar teeth when there are no prior fillings on biting surfaces.	Not Covered	100% Through age 18

TOTAL HEALTH PLUS BENEFITS		
If the member has multiple conditions, they will only be eligible for the benefit with the most cleaning(s) and/or gum maintenance treatments of a single condition. All benefits are covered at 100% unless otherwise noted.		
Diabetes • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Cancer (other than Oral) • Cleanings/Gum Maintenance • Fluoride Treatments	Additional 2x/yr Additional 2x/yr	Additional 2x/yr Additional 2x/yr
Oral Cancer • Cleanings/Gum Maintenance • Fluoride Treatments	Additional 2x/yr Additional 4x/yr	Additional 2x/yr Additional 4x/yr
Sjogren's Syndrome • Cleanings/Gum Maintenance • Fluoride Treatments	Additional 2x/yr Additional 4x/yr	Additional 2x/yr Additional 4x/yr
Stroke • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Heart Attack, Congestive Heart Failure • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Kidney Failure • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Organ Transplant • Cleanings/Gum Maintenance	Additional 2x/yr	Additional 2x/yr
Pregnancy (Expectant Mothers) • Cleanings/Gum Maintenance	Additional 1x/yr	Additional 1x/yr
Medical Risk for Cavities • Fluoride Treatments	Additional 3x/yr	Additional 3x/yr
BASIC CARE		
Fillings Once every two years per tooth per surface.	70% White-colored fillings limited to front teeth.	70% White-colored fillings limited to front teeth.
Root Canals	70%	70%
Gum/Bone Surgeries & Maintenance (non-medical risk factors) Once every three years per quad.	70%	70%
Oral Surgeries	70%	70%
MAJOR CARE		
Crowns	50% 1x/7yrs per tooth White crowns limited to front teeth and bicuspids.	50% 1x/7yrs per tooth White crowns limited to front teeth and bicuspids.
Fixed Bridges & Dentures	50% 1x/7yrs per tooth	50% 1x/7yrs per tooth
Implants	50%	Not Covered

OTHER SERVICES		
Adjunctive General Services	70%	70%
Emergency Treatment of Dental Pain (Palliative Treatment) Once per visit per dental office for relief of pain but not to cure	70%	70%
Athletic Mouth Guards	Not Covered	70% 1x/24-months Through age 18

CHILDREN - AGE 18 & UNDER - Special Consideration: Assessment of salivary flow is covered.

ADULTS – AGE 19 & OLDER - Special Consideration: Assessment of salivary flow is covered.

Access to HDS Information 24/7

Visit HDS Online at HawaiiDentalService.com to:

ACCESS YOUR ACCOUNT

- *Visit HawaiiDentalService.com*
- *Click "Member Login"*
- *Click "Create an account"*
- *Complete the "Account Registration" form*
- *Select "Yes" to be notified via e-mail when a claim is processed and "Yes" to "Request electronic Explanation of Benefits"*
- *Click "Register"*

SEARCH

- *For an HDS participating dentist in Hawaii, Guam or Saipan by specialty, location, handicap accessibility, weekend hours, and more*
- *For a Delta Dental Premier participating dentist on the Mainland or Puerto Rico by specialty, location, weekend hours and more*

DOWNLOAD & PRINT

- *A summary of your benefits for tax purposes*
- *Blank claim forms*
- *Your HDS membership card*
- *Your EOB statements*
- *HDS Notice of Privacy Practices*

CHECK

- *Whether you and/or your dependents are eligible for HDS benefits*
- *What dental services are covered by your plan*
- *What the limits are of each type of covered service and how much you have used*

VIEW

- *Your Explanation of Benefits (EOB) statements*
- *A list of frequently asked questions*
- *HDS contact information*

REQUEST

- *To receive emails when your claims are processed*
- *To receive EOB statements via email*
- *An HDS membership card to be mailed to you*

How to Contact HDS

Customer Service Representatives

From Oahu: (808) 529-9248

Toll-free: 1-844-379-4325

Customer Service Call Center Hours:

Monday – Friday: 7:30 AM – 4:30 PM HST

Excluding HDS observed holidays,

visit HawaiiDentalSevice.com/about/holidays

for our HDS' observed holiday schedule.

Walk-in Office Hours:

Monday – Friday: 8:00 AM – 4:30 PM HST

Send Written Correspondence to:

Hawaii Dental Service

Attn: Customer Service

900 Fort Street Mall, Suite 1900

Honolulu, HI 96813-3705

E-mail: CS@HawaiiDentalService.com

FAX:

From Oahu: (808) 529-9366

Toll-free fax: 1-866-590-7988

Kaiser Foundation Health Plan, Inc. – Hawaii
Infertility Treatment Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider amends the Kaiser Permanente Senior Advantage *Evidence of Coverage (EOC)* to include additional coverage for Infertility Treatment.

Benefit Summary

Description	Cost Share
Special Services for Women	
Artificial insemination (intrauterine insemination)	Office visit copay

Benefit Description

Special Services for Women

Artificial Insemination

We cover artificial insemination (intrauterine insemination) to determine infertility status in accord with Medical Group requirements and criteria.

Kaiser Foundation Health Plan, Inc. – Hawaii

Optical $150 Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider amends the Kaiser Permanente Senior Advantage *Evidence of Coverage (EOC)* to include additional coverage for Eyewear. The information in this Rider only applies to the Eyewear covered under this Rider.

Benefit Summary

Description	Cost Share
Optical Eyewear and Services	
Glasses frame/lens, lens treatments, corrective safety glasses, corrective sunglasses OR Contact lens/contact lens exam and fitting services	All costs greater than the $150 allowance per Accumulation Period
Medically required contact lenses	None
Pediatric Vision Care *	
Eye examination	None
One pair of polycarbonate single vision, lined bifocal or lined trifocal lenses	None
One frame	None
(in lieu of frames and lenses) one pair of non-disposable contact lenses or an initial supply of disposable contact lenses	None
Medically necessary contact lenses	None
One low vision hand-held or page magnifier device	None

* The benefits listed under Pediatric Vision Care section are limited to pediatric Members up to age 19. Such Members may combine their Pediatric Vision Care benefit and the allowance under Optical Eyewear and Services. See options under Pediatric Vision Care section.

Benefit Description

Optical Eyewear and Services and Pediatric Vision Care generally

Optical services must be received at, and optical eyewear must be purchased at Vision Essentials at Kaiser Permanente locations in order to be covered.

The allowances are a one-time benefit per Accumulation Period. If the entire allowance is not used during your initial visit, any unused portion of the allowance cannot be used for the remainder of that Accumulation Period and will not be carried forward to the next Accumulation Period.

Your allowance and any payments toward eyewear and services do not count toward the Annual Copayment Maximum.

We also cover routine eye examinations for eyeglasses in the Routine and Preventive section in *Chapter 3: Benefit Description* of this Guide. We also cover diagnosis, treatment and continued care for conditions related to disease or injuries of the eye by an eye specialist in the Office Visits section in *Chapter 3: Benefit Description* of this Guide. We also cover care in the hospital in the Total Care Services section in *Chapter 3: Benefit Description* of this Guide. For Senior Advantage members, eye exams and other eyewear are described in the Medical Benefits Chart.

Optical Eyewear and Services

You must choose to use your allowance toward either glasses or contacts.

Glasses frame/lens, lens treatments, prescription safety glasses, corrective sunglasses
Covered, when two lenses (at least one of which must have refractive value) are put into the frame. For members up to age 19, the lens material will be impact resistant polycarbonate.

Contact lens/contact lens exam and fitting services (when in lieu of frames and lenses)
Covered, for initial and refit of contact lens.

Medically required contact lenses
Covered, when medically required upon the prescription of a Kaiser Permanente Optometrist or Physician, that the contact lenses will provide a significant improvement in visual acuity or binocular vison not obtained with regular lenses. Thereafter, whenever a change in correction in either or both lenses is prescribed by a Kaiser Permanente Optometrist or Physician, lens or lenses with the new correction will be provided without charge.

Pediatric Vision Care

You must choose to use your pediatric vision care benefit for either glasses or contacts.

Eye examination
Covered, once per Accumulation Period.
Note: Additional eye examinations are covered at the usual office visit Cost Share in *Chapter 3: Benefit Description* of this Guide. Senior Advantage members, see the Medical Benefits Chart.

One pair of polycarbonate single vision, lined bifocal or lined trifocal lenses
Covered, once per Accumulation Period, when prescribed by a Kaiser Permanente optometrist or Physician. For members up to age 19, the lens material will be impact resistant polycarbonate.

One frame
Covered, once per Accumulation Period. Frame must be from the "value collection frames" available at Vision Essentials by Kaiser Permanente locations.

One pair of non-disposable contact lenses or an initial supply of disposable contact lenses (when in lieu of frames and lenses).
Covered, once per Accumulation Period. Includes fitting and dispensing of contact lenses. Covered contact lenses include:

- Standard (one pair annually): one contact lens per eye (total of two lenses), or
- Monthly (six-month supply): six lenses per eye (total of 12 lenses), or
- Bi-weekly (three-month supply): six lenses per eye (total of 12 lenses), or
- Dailies (one-month supply): 30 lenses per eye (total of 60 lenses)

Medically necessary contact lenses
Covered, when determined to be medically necessary by a Kaiser Permanente Optometrist or Physician. Contact lenses may be medically necessary and appropriate in the treatment of certain conditions such as Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular, and Astigmatism.

One low vision hand-held or page magnifier device
Covered, once every 24 months. Device includes fitting and dispensing.

Pediatric Vision Care options

Pediatric Members up to age 19 may combine the Pediatric Vision Care benefit and the allowance under Optical eyewear and services. Select one of these options:

- Eyeglasses: If pediatric Member chooses one pair of lenses and one frame from the "value collection", the eyeglass allowance may be applied toward this same or an additional pair of eyeglasses.
- Eyeglasses not from the "value collection": Instead of "value collection" frame, pediatric Members may apply the combined value of one pair of lenses and one frame from the "value collection" toward eyeglasses that are not from the "value collection." The eyeglass allowance may be applied toward this same pair of eyeglasses.
- Contact lenses: If pediatric Member chooses contact lenses, the contact lens allowance is applied toward additional contact lenses.

Services Not Covered

- Any medical services or eyewear from non-Kaiser Permanente providers or non-Kaiser Permanente optical facilities
- Optional eyeglass lens treatments such as anti-reflective coating, color coating and tinted lenses, polycarbonate lenses (for members over 19 years), photochromic lenses, ultraviolet protected lenses
- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Non-prescription eyewear such as colored contact lenses, non-prescription athletic eyewear, non-prescription industrial safety, and non-prescription sunglasses

- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Contact lens exams (if the allowance has been exhausted)
- All costs exceeding the stated allowance in the *Benefit Summary*.

Kaiser Foundation Health Plan, Inc. – Hawaii

Kaiser Permanente Fit Rewards

This amendment is part of the *Guide to Your Health Plan* (Guide) to which it is attached. This amendment becomes part of *Chapter 5: Wellness and Other Special Features under the Extra Services section*. The provisions of this Guide and the Evidence of Coverage (EOC) apply to this amendment. Kaiser Permanente Fit Rewards is a value-added program and not part of your medical benefits.

Kaiser Permanente Fit Rewards® Program provides these extra services

Kaiser Permanente Fit Rewards – Calendar Year	**<u>This Fit Rewards Program includes a basic fitness facility and exercise center membership</u>**
	• Eligible Members may enroll with a contracted network fitness facility
	• Program enrollment includes standard fitness club services and features including access to:
	  ○ cardiovascular equipment
	  ○ resistance/strength equipment
	  ○ classes which are routinely included in the general membership fee as part of the monthly fee, and for which the contracted fitness club does not typically require a fee per session, per week, per month, or some other time period
	  ○ amenities such as saunas, steam rooms, and whirlpools, where available
	• Eligible Members should verify services and features with the contracted fitness facility
	<u>Note:</u>
	• Eligible members have a $200 annual program fee✦
	• Eligible members must meet the 45-day, 30-minute per session activity requirement by end of calendar year 2026 to receive a reimbursement for fitness activities
	Or
		No Charge

	<u>Home Fitness Program</u> • Eligible Members may select one of the available home fitness kits per calendar year	**No Charge**
	<u>Fitness website</u> • All eligible Members have access to Optum One Pass Select web-based services such as facility provider search, enrollment functions, educational content, exercise videos, fitness tools and trackers.	

The following are excluded from the Program:

- Instructor-led classes for which the contracted fitness club charges a separate fee (and which are not routinely included in the general membership fee as part of the monthly membership fee).
- Personal trainers, classes, facility services, amenities, and products or supplies for which the contracted fitness facility charges Members an additional fee.
- Access to fitness or exercise facilities that are not part of the contracted network.
- Home fitness kits not provided through the program.
- Enrollment for Members not specifically listed as eligible for this program, as defined by the Group and Kaiser Permanente.
- Enrollment for Members under the age of 16.

✦ Members must pay their fee directly to Optum One Pass Select prior to using services. Kaiser Permanente Fit Rewards is a value-added service and not part of your medical benefits. Fees do not count toward the eligible Member's health benefit plan's Annual Copayment Maximum.

Kaiser Permanente shall not undertake to provide or to assure the availability and access to gym facilities approved by Optum One Pass Select.

Kaiser Permanente Fit Rewards is part of the fitness program, administered by Optum One Pass Select. Optum One Pass Select logo is a federally registered trademark of Optum One Pass Select and used with permission herein. The details of this program are subject to change. For the most current details and specifics, please visit kp.org/fitrewards.

Kaiser Foundation Health Plan, Inc. – Hawaii

Hearing Aid Rider – 20%

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of the Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider amends the Kaiser Permanente Senior Advantage Evidence of Coverage (EOC) to include coverage for Hearing Aids. The information in this Rider only applies to the Hearing Aids covered under this Rider.

	Benefits	You pay
	Up to 2 hearing aid(s), one for each hearing-impaired ear, once every 36 months, when prescribed by a Kaiser Permanente physician or Kaiser Permanente audiologist, and obtained from sources designated by Health Plan. **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. • Adjustments, repairs and rechecks are included while the hearing aid is within the manufacturer's warranty period. **Exclusions:** • After the manufacturer's warranty period, all hearing aid related costs, including but not limited to: fitting, rechecks, adjustments, and repairs for the hearing aid(s).	20% of applicable charges

Kaiser Foundation Health Plan, Inc. – Hawaii
Primary Care Office Visits for Children Rider

This Rider is included in the *Benefit Summary* in the front of the *Guide to Your Health Plan* (Guide). The provisions of this Guide and the Evidence of Coverage (EOC) apply to this Rider.

For Senior Advantage members, this Rider is included in the Medical Benefits Chart in the front of the *Evidence of Coverage (EOC).*

Benefit Summary

Description	Cost Share
Primary Care Office Visits for Children	
Primary care office visits for children through age 17	None

Benefit Description

Primary Care Office Visits for Children

Covered, for Members from birth through age 17 to treat illness and injury. Primary care must be received from a primary care provider at a Medical Office.

Notes:

- Specialty care office visits for Members (from birth through age 17) are covered upon payment of your Specialty Care Cost Share listed in the *Benefit Summary* in the front of this Guide.
- Well-child care office visits are covered at no charge as listed in the *Benefit Summary* in the front of this Guide. Well-child care office visits are described in *Chapter 3: Benefit Description*, Routine and Preventive section.
- For Members age 18 and older, primary care office visits are covered upon payment of the same office visit Cost Share listed in the *Benefit Summary* in the front of this Guide.