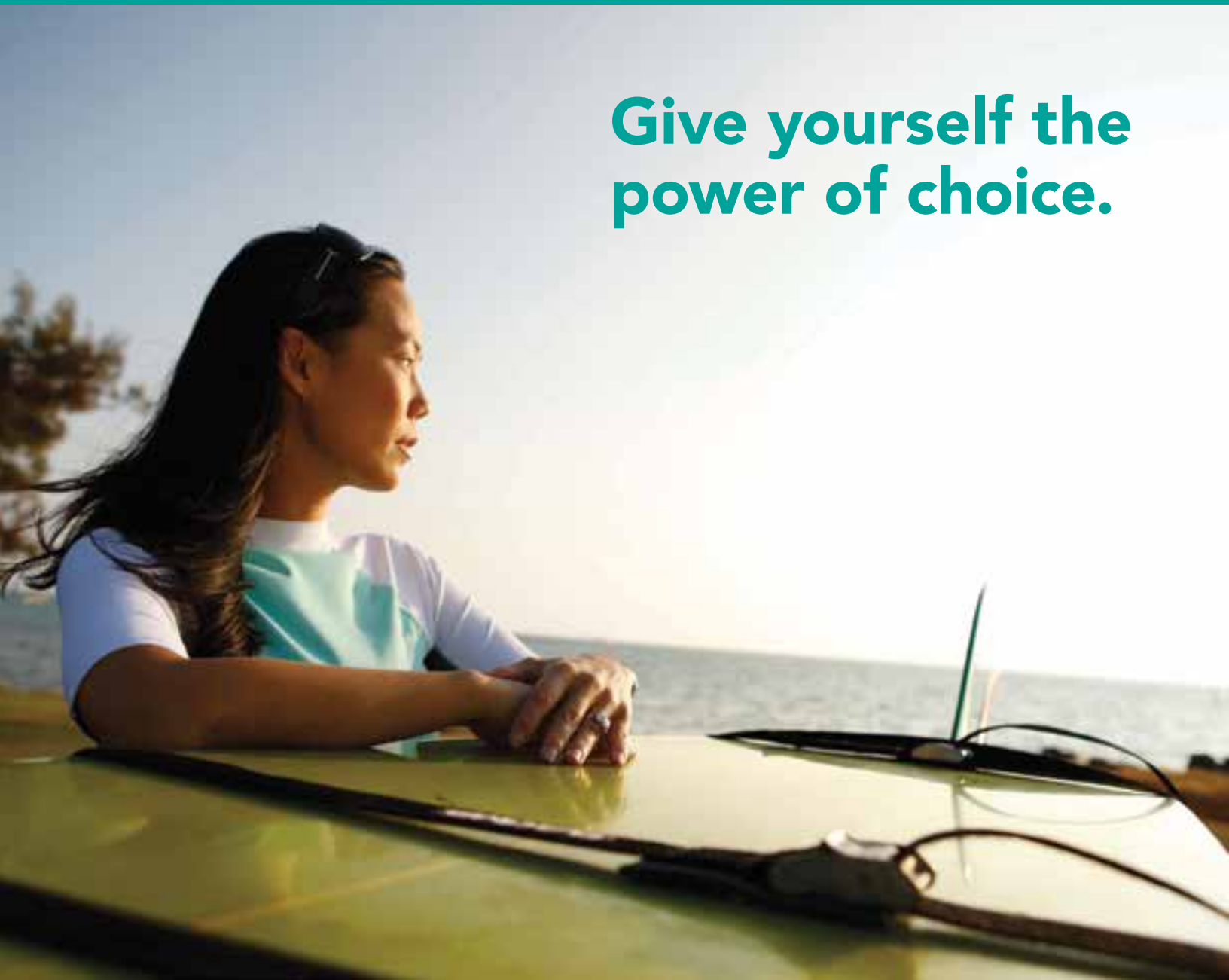
YOUR INTRODUCTION TO KAISER PERMANENTE

Added Choice®

MEMBER HANDBOOK

KAISER PERMANENTE® thrive



PERSONAL NOTES

My Kaiser Permanente medical facility:_____

My Kaiser Permanente medical facility phone number: _____

My personal physician's name: _____

My Kaiser Permanente Added Choice medical record number: _____

Notes: _____

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This *Added Choice Member Handbook* is not intended for and does not apply to the following members:

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

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

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

Information in this handbook is current as of August 2019 and may be subject to change without notice.

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WELCOME TO KAISER PERMANENTE

Thank you for choosing Kaiser Permanente. At Kaiser Permanente, we believe there's no better choice than choosing good health. That's why we provide you with the tools you need to get healthy and stay healthy. To help you get started, this handbook contains information about selecting a doctor, receiving care, filing claims, using pharmacy services, and making the most of your coverage. Please keep it handy as a reference tool.

YOUR CHOICE FOR GOOD HEALTH

Kaiser Permanente Added Choice® is a point-of-service health plan underwritten by Kaiser Foundation Health Plan, Inc. (Health Plan), and Kaiser Permanente Insurance Company (KPIC)[1]. With Added Choice, you get the flexibility you need and the choice of physicians you want. You and your family have the freedom to receive care from Kaiser Permanente providers, contracted providers, and non-contracted providers in your community. With providers and facilities located throughout the state of Hawaii, chances are you'll find us near your work or home. And, in most of our locations, all the services you need are available under one roof — so you don't need to run all over town to get routine care.

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

LET'S GET STARTED

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

[1]The contracted and non-contracted provider options of this plan are underwritten by KPIC, a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP).

IMPORTANT PHONE NUMBERS

IN HAWAII

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

Kaiser Permanente 24/7 Advice
Oahu: **808-432-2000**
Maui**: 808-243-6000**
Hawaii Island: **808-334-4400**
Kauai: **808-246-5600**
TTY: **711**

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

Maui Lani Medical Office
Monday–Friday, 5–8 p.m.
Saturday, Sunday, and most holidays, 8 a.m.–5 p.m.
Closed on Christmas and New Year's Day

Hawaii Poison Hotline.....1-800-222-1222

Open 24 hours a day, 7 days a week

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

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

Prescription Orders
Order most prescriptions online at **kp.org/pharmacycenter**

Order most medications (new and refills) by phone, 24 hours a day, 7 days a week:
808-643-RxRx (808-643-7979)

Kaiser Permanente Member Services
1-800-966-5955
TTY **711**
- Monday–Friday, 8 a.m.–5 p.m.
- Saturday, 8 a.m.–noon

OUTSIDE HAWAII

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

CALIFORNIA

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

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

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

IMPORTANT PHONE NUMBERS

COLORADO

Denver/Boulder area
303-338-3800

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

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

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

DISTRICT OF COLUMBIA

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

GEORGIA

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

MARYLAND

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

OREGON

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

VIRGINIA

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

WASHINGTON STATE

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

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

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

IMPORTANT PHONE NUMBERS

ABOUT THE ADDED CHOICE HELPLINE

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

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

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

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

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

The following are also available upon request:

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

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

MEMBER SATISFACTION PROCEDURE

We welcome your comments and concerns about care received from Kaiser Permanente providers. Your feedback is an encouragement when we meet your expectations and an opportunity for improvement when we fall short. You may provide your comments and concerns to your Kaiser Permanente personal physician or the departmental supervisor. You may also use the "Let Us Hear From You" customer feedback forms found in all Kaiser Permanente facilities, or call or write to Member Services. We'll respond within 30 days of receiving your comments or concerns.

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

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

ABOUT QUALITY CARE

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

MANAGING YOUR ADDED CHOICE PLAN

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

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

- Kaiser Permanente's full-service care delivery system
- Contracted providers in the community[1]
- Any licensed non-contracted provider[1]

UNDERSTANDING YOUR ADDED CHOICE BENEFITS

	The Kaiser Permanente provider option	The contracted provider option[1]	The non-contracted provider option[1]
Network of providers	You can see Kaiser Permanente Hawaii physicians at any one of our 22 facilities on Oahu, Maui, and Hawaii Island, and Kauai, and Kaiser Permanente contracted physicians on Kauai, Lanai, and Molokai. Most Kaiser Permanente locations offer primary care, lab, X-ray, and pharmacy services together in one place.	As of October 2018, you can see more than 2,500 Kaiser Permanente Insurance Company (KPIC) contracted providers and 164 contracted hospitals and care facilities in Hawaii.	You can see any other licensed provider anywhere in the world as long as it's a covered service under your plan and a type of care available within the United States.
Choosing a doctor	You choose your own primary care physician (practicing in internal medicine, pediatrics, or family medicine) to coordinate care and direct access to specialists. Women may also choose their own obstetrician-gynecologist.	You are not required to choose a primary care physician.	You are not required to choose a primary care physician.
Referrals	Your personal physician can refer you to a Kaiser Permanente specialist.	Referrals are not needed when seeking specialty care. Precertification is required for all inpatient admission and certain outpatient services. Failure to obtain precertification may result in a reduction in the benefits that would otherwise be payable.	Referrals are not needed when seeking specialty care. Precertification is required for all inpatient admission and certain outpatient services. Failure to obtain precertification may result in a reduction in the benefits that would otherwise be payable.

[1]*The contracted and non-contracted provider options of this plan are underwritten by KPIC, a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP).*

MANAGING YOUR ADDED CHOICE PLAN

UNDERSTANDING YOUR ADDED CHOICE BENEFITS

	The Kaiser Permanente provider option	The contracted provider option[1]	The non-contracted provider option[1]
Outpatient prescription drugs	Lowest out-of-pocket costs. You may have prescription orders mailed to your home for additional convenience and savings. Prescriptions written by contracted and non-contracted providers may be filled at any Kaiser Permanente pharmacy (subject to our drug formulary).	If your employer purchased coverage for outpatient prescription drugs, the out-of-pocket costs are generally higher than under the Kaiser Permanente provider option. You can visit any one of the contracted pharmacies in Hawaii for routine pharmacy services (**subject to the KPIC drug formulary**). Not all drug benefits are available at all contracted pharmacies.	No prescription drug coverage, except for FDA-approved contraceptives, oral chemotherapy drugs, and tobacco cessation drugs. You must pay the full cost of the drug and then file a claim with KPIC for reimbursement.
Lifetime maximum	Unlimited lifetime maximum.	No maximum benefit while insured.	
Annual deductibles	No annual deductible.	Accumulation period (calendar or plan year) deductible applies.	Accumulation period (calendar or plan year) deductible applies.
Out-of-pocket costs	Lowest	Generally higher than under the Kaiser Permanente provider option.	Generally higher than under the Kaiser Permanente provider option.
Claims	Virtually no paperwork or claims to file.	Most contracted providers file claims on your behalf. You are responsible for meeting the annual deductible and any applicable coinsurance. When you see a contracted provider, the negotiated rate equals the Maximum Allowable Charge (MAC), protecting you from balance billing.	You will be required to file a claim for reimbursement (if you do not assign benefits to your provider). The provider will bill you for the balance of expenses not covered by the KPIC reimbursement. You are responsible for meeting the annual deductible, any applicable coinsurance, and the difference between the MAC and the actual billed charge.
How much a $250 office visit for a covered expense would cost you[2]	Total billed charge: $250 Your copayment: $20 **Your total responsibility: $20**	**After annual deductible is met:** Total billed charge: $250 MAC: $180 You pay 20% of the MAC ($180 x 20%): $36 KPIC pays $144 ($180 x 80%). **Your total responsibility: $36**	**After annual deductible is met:** Total billed charge: $250 MAC: $180 You pay 20% of the MAC ($180 x 20%): $36 You are also responsible for the difference between the billed charge and MAC ($250 - $180 = $70) KPIC pays $144 **Your total responsibility: ($36 + $70): $106**

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

MANAGING YOUR ADDED CHOICE PLAN

ADDED CHOICE GLOSSARY

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

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

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

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

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

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

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

BEFORE YOU COME IN FOR A VISIT

UNLOCK THE DOOR TO GOOD HEALTH

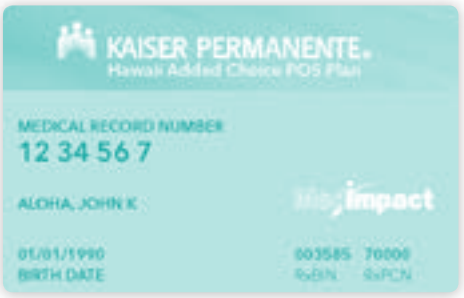
Your Kaiser Permanente Added Choice identification (ID) card is your key to accessing the health care services you need. Please carry your ID card with you at all times. You'll need to present your ID card along with a valid photo ID card every time you receive care. If you lose or damage your ID card,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

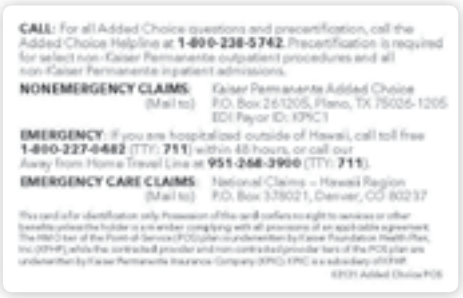
Your new ID card, as well as any replacement card, will be mailed to you. New Kaiser Permanente members should carry a temporary ID card (found on the last page of the enrollment form) for at least 10 days or until the permanent one is mailed to you.

Your ID card contains your medical record number, which you'll need in order to identify yourself when you call Kaiser Permanente. It's a good idea to write down your medical record number inside the front cover of this handbook. We may provide your medical record number to your employer or group administrator for enrollment and billing purposes.

Please present a valid photo ID with your Kaiser Permanente Added Choice ID card when you check in at the clinic. Minors may present a school photo ID. If a minor does not have a photo ID, his or her parent or legal guardian may present a photo ID. We ask for photo IDs as part of our effort to protect your medical information and prevent identity theft.

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





Protecting you from health care fraud

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

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

USING YOUR IN-NETWORK BENEFITS AT KAISER PERMANENTE

MAKE YOUR CARE PERSONAL

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

You can maximize covered benefits through your choice of providers. As an Added Choice member, you may choose Kaiser Permanente providers, contracted providers, or non-contracted providers. In most cases, receiving care from Kaiser Permanente providers means that you'll receive the highest level of coverage from your Added Choice plan and will likely pay the lowest level of out-of-pocket costs. Your medical care within Kaiser Permanente is the responsibility of the Hawaii Permanente Medical Group, Inc., a corporation of more than 600 health care providers.

HOW TO CHOOSE YOUR DOCTOR AT KAISER PERMANENTE

Select your Kaiser Permanente personal physician from any of our available providers. Learn about our providers in our *Added Choice Physicians and Locations Directory*, biography cards at our reception counters, and online at **kp.org/chooseyourdoctor**, where you can search our online doctor profiles. You can change your Kaiser Permanente personal physician at any time and for any reason.

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

Step 2: Choose a doctor from one of three primary care options:

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

Step 3: To choose and change your doctor, simply call your care facility or go online at **kp.org/chooseyourdoctor.**

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

USING YOUR IN-NETWORK BENEFITS AT KAISER PERMANENTE

APPOINTMENTS

Two easy ways to schedule your Kaiser Permanente appointments:

Visit **kp.org/appointments** on your computer or use the Kaiser Permanente mobile app and tap Appointments on the app dashboard. You can schedule office or phone visits with your primary care physician, same-day adult care visits, and some specialty appointments.

- Call your doctor's office.

Preparing for your appointment:

- Check in with your Kaiser Permanente Added Choice ID card and a valid photo ID.
- If you have additional health insurance in addition to Kaiser Permanente, please bring the insurance card with you.
- Bring the names of any medications you are taking, including non-prescription medicines, so we can make sure that your prescriptions are uninterrupted and your doctor has all the information needed to care for you.
- Tell the doctor about any treatments you are currently receiving and feel free to ask questions.

To cancel an appointment, visit **kp.org/appointments** or call your Kaiser Permanente medical facility. If you're bringing in a child that is not your own, please get an authorization form from Member Services or have a notarized Health Care Power of Attorney form.

SELF-REFERRALS AND SPECIALISTS

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

- Eye examinations for glasses and contact lenses
- Family medicine
- Health education
- Internal medicine
- Mental health and wellness
- Pediatrics
- Physical therapy
- Social work
- Sports medicine

The list of specialties that don't require a referral vary by island. For services not listed above, your doctor may refer you to a specialist when it's medically necessary. Members on Kauai, Molokai, or Lanai may self refer to contracted network providers, but certain treatments may require a referral. For details, please call Member Services at **1-800-966-5955** (TTY 711).

TRANSPORTATION SERVICES

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

- Honolulu Medical Office
- Kapolei Clinic
- Koolau Medical Office
- Mapunapuna Medical Office
- Nanaikeola Clinic
- Waipio Medical Office
- Daniel K. Inouye International Airport Interisland Terminal

Shuttle operates Monday–Friday, except holidays. Schedules and sign-ups are posted at each location. You can also find the shuttle schedule at **kp.org/shuttle/hi**.

USING YOUR IN-NETWORK BENEFITS AT KAISER PERMANENTE

NEIGHBOR ISLAND CONCIERGE

If you live on a neighbor island and your doctor refers you to a specialist, we may recommend you get treated on Oahu. You will be cared for by a team of physicians upon your arrival who have access to facilities and equipment that may not be available on your island. Our complimentary concierge service offers shuttle and ground transportation information, hotel and housing recommendations, and tips on making your stay as easy as possible.

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

TRAVEL DEPARTMENT

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

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

KAISER PERMANENTE 24/7 ADVICE LINE

If you're not feeling well and our offices are closed, call our 24/7 advice line at no cost. Registered nurses can provide advice when medically appropriate or direct you to the appropriate place for care. Please have your member ID number (on the front of your Kaiser Permanente ID card), or the medical record number of the person for whom you're calling.

Call us 24/7 at:

- Oahu: **808-432-2000**
- Maui: **808-243-6000**
- Hawaii Island: **808-334-4400**
- Kauai: **808-246-5600**
- TTY **711**

KAISER PERMANENTE AFTER-HOURS CARE

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

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

Please call **808-432-7700** to schedule an appointment. Park in the Moanalua Medical Center garage. Use the main entrance to go to the first-floor cashier and check in. The cost of an after-hours visit is the same as a routine office visit.

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

Patients are welcome to walk in, patients are seen in the order of arrival based on the severity of symptoms. The cost of an after-hours visit is the same as a routine office visit.

USING YOUR IN-NETWORK BENEFITS AT KAISER PERMANENTE

URGENT CARE

ON HAWAII ISLAND

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

Hilo Urgent Care Center, LLC
670 Kekuanaoa Street
Hilo, HI 96720
Monday through Friday, 5 to 8:30 p.m.
Saturday and Sunday, 8:30 a.m. to 4:30 p.m.
808-969-3051
(X-ray services available)

Waimea Urgent Care
65-1230 Mamalahoa Highway, A10
Waimea, HI 96743
Monday through Friday, 5 to 7 p.m.
Saturday and Sunday, 8 a.m. to 4 p.m.
808-885-0660

Keaau Urgent Care Center, LLC
16-590 Old Volcano Road
Keaau, HI 96749
Monday through Friday, 5 to 6:30 p.m.
Saturday and Sunday, 8:30 a.m. to 4:30 p.m.
808-966-7942
(Limited X-ray services available)

Aloha Kona Urgent Care
75-5995 Kuakini Highway, Suite 213
Kailua-Kona, HI 96740
Monday through Friday, 5 to 6:30 p.m.
Saturday and Sunday, 1 to 9 p.m.
808-365-2297

Keauhou Urgent Care Center
Keauhou Shopping Center
76-6831 Alii Drive, Suite 416
Kailua-Kona, HI 96740
Monday through Friday, 5 to 7 p.m.
Saturday and Sunday, 9 a.m. to 7 p.m.
808-322-2544

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

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

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

ON MAUI

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

Hana Health Clinic
4590 Hana Highway
Hana, HI 96713
Monday through Thursday, 7 to 8 a.m., 5 to 6 p.m.
Friday, 7 to 8 a.m.
Saturday, 8 a.m. to noon
808-248-8294

Doctors On Call Maui's Urgent Care
Times Market Place/North Kaanapali
3350 Lower Honoapiilani Road, Unit 211
Lahaina, HI 96761
Monday through Friday, 5 p.m. to 9 p.m.
Saturday and Sunday, 8 a.m. to 9 p.m.
808-667-7676

Doctors On Call Maui's Urgent Care
Hyatt Regency Maui
200 Nohea Kai Drive., #100
Lahaina, HI 96761
Monday through Friday, 8 a.m. to 5 p.m.
808-667-7676

Minit Medical
Lahaina Gateway Shopping Center
305 Keawe Street, #507
Lahaina, HI 96761
Monday through Friday, 5 to 6 p.m.
Saturday, 8 a.m. to 6 p.m.
Sunday, 8 a.m. to 4 p.m.
808-667-6161

Minit Medical
Maui Marketplace
270 Dairy Road, #239
Kahului, HI 96732
Monday through Friday, 5 to 7 p.m.
Saturday, 8 a.m. to 6 p.m.
Sunday, 8 a.m. to 4 p.m.
808-667-6161

Minit Medical
1325 S. Kihei Road, #103
Kihei, HI 96753
Monday through Friday, 5 to 7 p.m.
Saturday, 8 a.m. to 6 p.m.
Sunday, 8 a.m. to 4 p.m.
808-667-6161

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

- Kauai Urgent Care
  4484 Pahee St.
  Monday through Friday, 7 to 7 p.m.
  Saturday and Sunday, 8 a.m. to 7 p.m.
  808-245-1532

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

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

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

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

USING YOUR IN-NETWORK BENEFITS AT KAISER PERMANENTE

EMERGENCY CARE

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

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

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

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

- Severe pain
- Suspected heart attack or stroke
- Extreme difficulty breathing
- Bleeding that will not stop
- Major burns
- Seizures
- Sudden onset of severe headache
- Suspected poisoning

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

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

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

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

UTILIZATION MANAGEMENT FOR EMERGENCY SERVICES

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

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

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

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

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

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

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

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

After regular business hours, your message will be forwarded to our UM team and your call will be returned the next business day. You may also fax us at **808-432-7419**.

USING YOUR IN-NETWORK BENEFITS AT KAISER PERMANENTE

HOSPITAL SERVICES

Kaiser Permanente Hawaii's Moanalua Medical Center is a full-service hospital. Integrated and comprehensive quality care is what sets us apart. Our specially-trained clinicians and state-of-the-art facility provide medical, surgical, perinatal, neonatal, pediatric, and intensive care for acute illness and injury. The Center also includes an ambulatory surgery and recovery (ASR) department, ambulatory treatment center (ATC), a clinical decision unit for observation stays (CDU), operating rooms, and emergency services.

Admission is based on a physician's review of your medical condition. For planned admissions, such as elective (nonurgent) surgery, the admitting physician will notify you when to report to the hospital. We also work closely with you to plan a smooth and timely discharge.

Neighbor Island Members

Our physicians will direct you to a hospital on your island. This may include:

Maui
Maui Memorial Medical Center
Kula Hospital

Hawaii Island
Kona Community Hospital
Hilo Medical Center
North Hawaii Community Hospital

Kauai
Wilcox Memorial Hospital
West Kauai Medical Center
Sam Mahelona Memorial Hospital

Molokai
Molokai General Hospital

Lanai
Lanai Community Hospital

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

GETTING CARE ON LANAI AND MOLOKAI

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

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

USING YOUR IN-NETWORK BENEFITS AT KAISER PERMANENTE

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

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

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

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

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

LIMIT ON SUPPLEMENTAL CHARGES

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

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

PHARMACY SERVICES

PHARMACY SERVICES

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

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

COVERED DRUGS

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

DRUGS NOT COVERED

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

TRANSFER YOUR PRESCRIPTIONS

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

PRESCRIPTION ORDERS*

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

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

- For the quickest turnaround time, order online at **kp.org/pharmacycenter** or through your Kaiser Permanente mobile app.
- Order via Kaiser Permanente Hawaii's automated prescription refill service by calling **808-643-RxRx** (808-643-7979). You'll have the following options:
  - To order a refill, check prescription status or hours of operations, press **1.**
  - To contact the Mail Order Pharmacy, press **5**.
  - To speak with a member of our pharmacy team, press **3**.

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

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

PHARMACY Q&A

Q: What is the advantage of using Kaiser Permanente's mail-order pharmacy service?

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

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

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

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

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

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

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

Q: May I use a Kaiser Permanente pharmacy to fill a prescription written by an Added Choice contracted or non-contracted physician?

A: Yes, your prescriptions can be filled at a Kaiser Permanente pharmacy, through our mail order pharmacy service, or at contracted pharmacies designated by Kaiser Permanente if the medication is an approved Kaiser Permanente formulary medication and in stock or a non-formulary drug is deemed medically necessary by your physician.

Q: Will a prescription from an Added Choice contracted or non-contracted physician for a non-formulary medication be covered at an Added Choice contracted pharmacy?

A: Yes, subject to KPIC Utilization Management Program, the non-formulary medication will be covered if filled at a designated Added Choice contracted pharmacy, according to your plan's drug benefit.

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

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

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

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

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

USING YOUR OUT-OF-NETWORK BENEFITS
WITH CONTRACTED AND NON-CONTRACTED PROVIDERS

CONTRACTED PROVIDERS

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

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

NON-CONTRACTED PROVIDERS

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

OUT-OF-POCKET BENEFIT MAXIMUMS

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

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

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

APPOINTMENTS

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

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

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

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

See how to file a claim at "Filing a nonemergency care claim for payment" on page 41 of this handbook. Any applicable deductibles must be paid per member/family before benefits may become payable.

USING YOUR OUT-OF-NETWORK BENEFITS
WITH CONTRACTED AND NON-CONTRACTED PROVIDERS

PRECERTIFICATION OF SERVICES

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

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

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

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

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

KEEPING YOU HEALTHY AT KAISER PERMANENTE

CONNECT TO CARE ANYTIME, ANYWHERE

Managing your health online has never been more convenient. Whether you're at home or on the go, **kp.org** and the Kaiser Permanente app give you a simple, secure way to keep up with your care.

Manage your care at **kp.org**:[1]

- View most lab results
- Email your care team with nonurgent questions
- Refill most prescriptions
- Schedule most appointments
- Pay bills and estimate costs

Connect to better health with online programs to help you lose weight, quit smoking, reduce stress, and more – all at no cost. Learn more at **kp.org/healthylifestyles**.

CREATING A KP.ORG ACCOUNT IS EASY

Go to **kp.org/newmember** and follow the sign-on instructions. You'll need your medical record number, which you can find on your member ID card.

GET FIT. GET REWARDED.

In 2019, Kaiser Permanente Fit Rewards is expanding to all fitness centers statewide.[2]

You can still earn a free gym membership at certain gyms or enjoy discounted rates on newly added fitness centers. Whether you're into yoga or high-intensity fitness training, you can earn a $200 reward if you meet the program requirements.[3] Learn more at **kp.org/fitrewards.**

[1] These features are available when you get care at Kaiser Permanente facilities.

[2] Qualifying fitness centers must be qualified fitness organizations operating for the general public; must offer regular cardiovascular, flexibility, and/or resistance training exercise programs; established physical facility must offer a membership agreement; and must be overseen by staff. Fitness centers outside of the 50 U.S. states and the District of Columbia do not qualify.

Kaiser Permanente Fit Rewards is administered by American Specialty Health Fitness, Inc. through its Active&Fit® program. American Specialty Health Fitness, Inc. (ASH Fitness) is a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit is a trademark of ASH and used with permission herein.

[3] Earn your annual $200 program fee back by exercising 45 days a year for at least 30 minutes per session at a participating fitness center.

KEEPING YOU HEALTHY AT KAISER PERMANENTE

CHOOSEHEALTHY™

As a Kaiser Permanente Hawaii member, you have access to discounts on health products and services through ChooseHealthy. Enjoy reduced rates on services that can help you stay healthy – like chiropractic, acupuncture, massage therapy, and more. Explore your options at **kp.org/choosehealthy.***

Please note that the ChooseHealthy program is a discount program; it is not insurance. You can access services from any ChooseHealthy participating provider; referral from a Kaiser Permanente primary care physician is not required. You're responsible for paying the discounted fee directly to the contracted provider.

You can also call toll free **1-877-335-2746**, Monday through Friday, 5 a.m. to 6 p.m., Pacific time, for more information on ChooseHealthy. The ChooseHealthy program is provided by ChooseHealthy, Inc., and is a subsidiary of American Specialty Health, Inc. (ASH). ChooseHealthy is a trademark of ASH and used with permission herein.

*The ChooseHealthy products and services are provided by entities other than Kaiser Permanente, and Kaiser Permanente disclaims any liability for them.

PREVENTIVE CARE GUIDELINES

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

As your health care partner, we'll do our part by focusing on early detection and timely treatment of disease. To monitor your health and identify symptoms at an early stage, we ask that you follow these preventive care guidelines.

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

PREVENTIVE CARE GUIDELINES FOR CHILDREN AND ADOLESCENTS

Age	Vaccination or screening test*	Checkup
INFLUENZA SEASONALLY FROM AGE 6 MONTHS THROUGH LIFE		
Birth	Hep B (hepatitis B)	
2 weeks	Well child visit	
2 months	DTaP (diphtheria/tetanus/acellular pertussis), Hib (Haemophilus influenzae type B), 2nd Hep B, polio vaccine, PCV (pneumococcal conjugate vaccine), 1st rotavirus oral vaccine	Well-child visit
4 months	2nd DTaP, 2nd Hib, 2nd polio vaccine, 2nd PCV, 2nd rotavirus oral vaccine	Well-child visit
6 months	3rd DTaP, 3rd Hib (if needed), 3rd Hep B, 3rd polio vaccine, 3rd PCV, influenza seasonally to age 18, 3rd rotavirus oral vaccine (if needed)	Well-child visit
9 months	Complete blood count, TB (tuberculosis) skin test if high risk; lead screening	Well-child visit
12 months	1st MMR (measles/mumps/rubella), 1st Hep A (hepatitis A), 1st varicella (chickenpox)	Well-child visit
15 months	4th DTaP, Hib, and PCV at age 15 to 18 months	Well-child visit
18 months	2nd Hep A, 4th DTaP, Hib, and PCV if not completed at 15 months	Well-child visit
2-6 years	2nd MMR, 2nd varicella (chickenpox), ages 3 to 6 years: TB skin test once, booster DTaP, booster polio	Every year
7-13 years	Ages 11 to 12: Tdap (tetanus/diphtheria/ acellular pertussis); 1st MCV4 (meningococcal conjugate vaccine); HPV (human papillomavirus) vaccine series for females and males ages 11 to 26 years; diabetes and lipid screening for high-risk individuals	Every other year (annually if required for school or sports)
14-21 years	Tdap if not given previously (pregnant women require an extra dose of Tdap to protect their fetus), then Td (tetanus/diphtheria) every 10 years; 2nd MCV4 at ages 16 to 18 years, HPV series if not given previously, annual chlamydia test for females if ever sexually active; complete blood count for females (once); diabetes and cholesterol screening for high-risk individuals	Every other year (annually if required for school or sports)

*Vaccine and screening schedule subject to change. These recommended preventive guidelines are subject to change based on the most current evidence and may not reflect what are covered benefits.

SELF-CARE AND RISK COUNSELING FOR ALL AGES

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

New medical technologies

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

PREVENTIVE CARE GUIDELINES FOR ADULTS

Action	Age	Frequency
VACCINATIONS		
Influenza (flu)	18 years and older	Seasonally
Zoster (shingles)	50 years and older	One 2 dose series, 2 to 6 months apart
Td (tetanus/diphtheria)	18 years and older	Once every 10 years
Tdap (tetanus/diphtheria/ acellular pertussis)	18 years and older	Once in place of Td. Pregnant women require an extra dose of Tdap to protect their fetus with each pregnancy
Pneumococcus (pneumonia)	19-64 years 65 years and older	If high-risk conditions, such as diabetes, asthma, smoking, etc., exist Once, regardless of risk factors
HPV (human papillomavirus) vaccine series for females and males	18-26 years	Once (series of 3 injections) if not completed previously
CANCER RISK SCREENINGS		
Colon Cancer **iFOBT (stool test for blood)**	50-75 years	Once a year Every 10 years or more frequently as indicated after discussion with your health care provider
Breast Cancer **Mammogram**	40-49 years 50-74 years	Consider after discussion with your health care provider Every 1-2 years
Cervical Cancer **Pap test**	21-65 years	For ages 21-29, every 3 years; for ages 30-65, every 5 years with HPV co-testing or more frequently if high risk
Prostate Cancer **PSA with rectal exam**	50 years	Consider after discussion with your health care provider

PREVENTIVE CARE GUIDELINES FOR ADULTS

Action	Age	Frequency
OTHER PREVENTIVE SERVICES		
Blood pressure	18 years and older	Every 2 years
Cholesterol evaluation	18 years and older 40 years and older	Once if never done before Every 5 years or more frequently for higher-risk individuals
Diabetes	45 years	Once every 3 years or more frequently for higher-risk individuals
Bone mineral density test for osteoporosis	65 years	Once
SEXUALLY TRANSMITTED DISEASES		
Chlamydia test	18-25 years	Once a year for sexually active women

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

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

MASTECTOMY-RELATED COVERAGE

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

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

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

KEEPING YOU HEALTHY AT KAISER PERMANENTE

KAISER PERMANENTE ON-THE-JOB® OCCUPATIONAL HEALTH SERVICES

While our goal is to help you stay safe and healthy, accidents do happen. When they do, you can be sure that Kaiser Permanente On-the-Job® is here for you. We have dedicated Occupational Health Services (OHS) clinics located on Oahu, Maui, and Hawaii Island. Most of our clinics have lab, X-ray, and pharmacy services at the same location, so you won't have to run all over town for follow-up services. Same-day, after-hours, and emergency care are available too.

Kaiser Permanente On-the-Job is a coordinated care program that focuses on your safety and health needs in the workplace. We're here for all employees — not just Kaiser Permanente members, but workers who have chosen other plans, too. Our goal is to help you get the care you need so that you can return to work as soon as it's safe for you.

The doctors and nurses at our OHS clinics treat work-related injuries and illnesses daily. If you require further care, we may refer you to one of the many medical specialists available within the Kaiser Permanente network. We also may refer you to a specialist outside of Kaiser Permanente. Because our goal is to give you the time and attention that you deserve, a nurse is available to help guide your treatment through the recovery stages. If you have any questions about your care, contact the OHS clinic coordinator who will assist you.

At Kaiser Permanente On-the-Job, we want to help you stay safe and healthy at work. To help reduce the chances of workplace injuries and illnesses, take advantage of our lifestyle programs offered at our clinics.

For more information, call Kaiser Permanente On-the-Job Customer Service:

808-432-2208 (Oahu)
1-888-683-2208 (neighbor islands)

VISION ESSENTIALS BY KAISER PERMANENTE

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

Oahu

Honolulu Medical Office
1010 Pensacola St.
Honolulu, HI 96814

Optical Dispensing:
808-432-2170
Eye Appointments:
808-432-2000

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

Optical Dispensing:
808-432-3461
Eye Appointments:
808-432-2000

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

Optical Dispensing:
808-432-3126
Eye Appointments:
808-432-2000

KEEPING YOU HEALTHY AT KAISER PERMANENTE

Maui

Kihei Clinic
1279 S. Kihei Rd., #120
Kihei, HI 96753

Optical Dispensing:
808-891-6828
Eye Appointments:
808-243-6000

Lahaina Clinic
910 Wainee St.
Lahaina, HI 96761

Optical Dispensing:
808-662-6925
Eye Appointments:
808-243-6000

Wailuku Medical Office
80 Mahalani St.
Wailuku, HI 96793

Optical Dispensing:
808-243-6203
Eye Appointments:
808-243-6000

Hawaii Island

Hilo Clinic
1292 Waianuenue Ave.
Hilo, HI 96720

Optical Dispensing:
808-934-4050
Eye Appointments:
808-334-4000

Kona Medical Office
74-517 Honokohau St.
Kailua-Kona, HI 96740

Optical Dispensing:
808-334-4420
Eye Appointments:
808-334-4000

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

EYE CARE COVERAGE IN KAISER PERMANENTE BASE BENEFIT

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

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

FEE-FOR-SERVICE OFFERINGS*

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

THE HEARING SERVICE CENTER BY KAISER PERMANENTE

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

1-866-400-1760 for an appointment

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

*Kaiser Permanente members typically have coverage for medically necessary eye and hearing examinations, which are generally conducted at Kaiser Permanente facilities. Otherwise, the services described here are provided on a fee-for-service basis, separate from and not covered under your health plan benefits. Clinical services are provided by providers or contractors of Hawaii Permanente Medical Group, Inc. Results of services vary among patients and cannot be guaranteed. Hawaii Permanente Medical Group, Inc., Kaiser Foundation

Health Plan, Inc., and Kaiser Foundation Hospitals have a financial interest in the provision of these services. For specific information about your health plan benefits, please see your *Benefits Summary.*

THE VISION CORRECTION CENTER BY KAISER PERMANENTE

LASIK VISION CORRECTION

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

PREMIUM INTRAOCULAR LENS IMPLANTS (IOL)

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

1-866-400-1760 for an appointment

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

THE AESTHETIC CENTER BY KAISER PERMANENTE

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

1-866-400-1760 for an appointment

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

COSMETIC SKIN CARE SERVICES

Our cosmetic skin care services vary by location and include:

- State-of-the-art laser treatments for skin resurfacing,photo rejuvenation, brown spot reduction, and permanent hair reduction
- Injectables for wrinkles, including Botox® Cosmetic, Dysport®, Restylane®, Juvederm®, and Sculptra® Aesthetic
- Kybella® treatment for double chins
- Removal of benign skin growths
- Aesthetician services for microdermabrasion, facial peels, skin care products, and complimentary skin care evaluations by an aesthetician
- Permanent make-up for eyebrows and eyeliner

AESTHETIC SURGERY

Our professional team includes experienced surgeons who are recognized leaders in their specialty that perform:

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

GETTING CARE OUTSIDE OF HAWAII

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

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

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

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

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

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

For more information about emergency care under your Added Choice plan, please see page 15 of this handbook and refer to your plan *Benefits Summary* and *KPIC Certificate of Insurance.*

As an Added Choice member, you may receive medical services at Kaiser Permanente facilities in our other regions when you are visiting the area. Visiting member services are different from the coverage you receive in your home region. Be sure you have your Kaiser Permanente Added Choice ID card with you at all times. The visiting member program is not a plan benefit but a service offered to members as a courtesy. Changes to the program may occur at any time. For locations of Kaiser Permanente facilities in our other regions, please go to **kp.org** or contact Member Services at **1-800-966-5955**.

FILING APPEALS, CLAIMS, AND REQUESTS

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

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

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

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

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

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

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

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

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

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

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

When received, your appeal will be prepared for an internal review. Appeal reviews will consider all information you submit (whether or not that information was submitted with your initial request for payment or coverage), will be decided by a different reviewer than the person who denied your initial request, and will not give deference to the initial decision you're appealing. When you appeal, you may give testimony in writing or by telephone. Please call Member Services to get information about giving testimony by phone. If we consider, rely upon, or generate any new or additional evidence in our appeal review, or if our appeal decision is based on a new or additional coverage rationale, we will provide you, free of charge, such evidence or coverage rationale as soon as possible and give you a reasonable opportunity to respond before our decision is

due. If you do not respond before we must make our decision, our decision will be based on the information that we have on hand. If we continue to deny your request after our appeal is completed, our written notice to you will include the specific reasons for the decision and refer to the specific plan provisions on which our decision was made. If you are not satisfied with our decision, you may request external review as noted later in this section.

Appeals related to claims for payment (post-service requests) filed by members on employer group plans will be processed through a single level of review. When received, your post-service appeal will be prepared for review. Generally, we will provide you with our written decision within 30 calendar days.

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

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

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

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

Para obtener asistencia en Español, llame al **808-432-5955** ó **1-800-966-5955.**

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **808-432-5955** o di kaya'y **1-800-966-5955**.

如果需要中文的帮助, ?拨打?个号码 **808-432-5955** 或者**1-800-966-5955**。

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **808-432-5955** doodaii **1-800-966-5955**.

HOW TO FILE AN APPEAL ON A CLAIMS DECISION FOR OUT-OF-NETWORK BENEFITS

STANDARD APPEAL

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

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

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

Kaiser Permanente Added Choice
P.O. Box 261205
Plano, TX 75026-1205

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

When received, your appeal will be acknowledged and prepared for review. Generally, we'll provide you with our written decision in 30 calendar days. Our decision will include the specific reason for the decision and reference the specific plan provision on which our decision is made. If you are not satisfied with our decision, you may request an external appeal (see section on Filing an External Appeal with an Independent Review Organization).

EXPEDITED APPEAL

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

You or your physician may request an expedited appeal anytime by calling **1-866-233-2851** toll free, or by faxing, writing, or delivering your request to the same address and phone numbers listed for standard appeals. If we determine that your request does not meet the criteria for an expedited appeal, we'll automatically review your written appeal under the 30-day process. Different procedures apply to the following plans: Kaiser Permanente Senior Advantage, Kaiser Permanente Medicare Cost, Kaiser Permanente QUEST Integration, the Federal Employees Health Benefits Program, and Kaiser Permanente Individuals and Families. Members on these plans should consult their respective *Evidence of Coverage*, handbook, or brochure for a description of the claims and appeals procedures that apply to them.

FILING AN EXTERNAL APPEAL WITH AN INDEPENDENT REVIEW ORGANIZATION

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

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

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

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

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

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

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

EXPEDITED EXTERNAL APPEAL

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

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

The IRO will perform the external review by considering the same types of information as noted earlier under the standard process. The

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

EXTERNAL REVIEW REQUESTS FOR EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR TREATMENTS

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

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

For non-expedited requests involving an experimental or investigational service or treatment that are determined eligible for external review, the commissioner has three business days after the eligibility decision was made to assign the case to an IRO approved by the Insurance Division and provide Kaiser Permanente with the name of the IRO. We must submit to the IRO within five business days of our receipt of the name of the IRO all the documents and information that we considered during our internal review of your request. You or your authorized representative may submit additional written information to the IRO within five business days of your receipt of the Insurance Division's notice that your case was assigned to an IRO. The IRO must select one or

more clinical reviewers within three business days after it was assigned to perform the external review. Each reviewer must provide its opinion to the IRO in writing within 20 days of the date the IRO was assigned to perform the review. The IRO must then provide its written decision to you, your authorized representative, and Kaiser Permanente within 20 days after the opinions were received. The IRO must decide to reverse or uphold Kaiser Permanente's adverse decision in the same manner discussed earlier based on a majority of the clinical reviewers' recommendations.

PROCEDURES APPLICABLE TO ALL REQUESTS FOR EXTERNAL REVIEW

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

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

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

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

FILING AN EMERGENCY CARE CLAIM FOR PAYMENT

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

- Care was a covered service under your Group Medical and Hospital Service Agreement.

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

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

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

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

If you paid for services, you may file a claim by sending your name, the patient's name and health plan medical record number, paid receipts, medical documentation, and a written statement describing the sequence of events to the following address within 90 days (or as soon as reasonably possible) after you received the out-of-plan emergency or out-of-area urgent care:

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

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

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

You may request a free copy of (1) all documents and information relevant to your request for payment or coverage; (2) any rule, guideline, or protocol Health Plan relied upon in denying the service or supply you requested; and (3) the

identity of any experts whose advice was obtained by us in connection with our denial of your request. You can request the information by calling Member Services at **1-800-966-5955**.

FILING A NONEMERGENCY CARE CLAIM FOR PAYMENT

Have your provider file on a standard CMS-1500 claim form and mail to:

Kaiser Permanente Claims Administration
P.O. Box 378021
Denver, CO 80237

Upon your signed authorization, payments for services will be sent directly to the provider of services. We'll mail you an E*xplanation of Benefits* showing the services performed, the actual charge, any adjustments to the charge, and the amount paid by KPIC. The *Explanation of Benefits* is not a bill. However, it is an important document and should be saved with other personal medical records.

REQUESTS FOR SERVICES OR SUPPLIES YOU HAVE NOT RECEIVED AT THE IN-NETWORK BENEFIT LEVEL

STANDARD DECISION

You, your authorized representative, or treating physician may request that we provide health care services or supplies you have not received but believe you're entitled to receive through Kaiser Permanente at the in-network benefit level. These requests should be submitted in writing to the following address:

Kaiser Foundation Health Plan, Inc.
Authorizations and Referrals Management
2828 Paa St.
Honolulu, HI 96819

Your written submission should include your name, the patient's name and medical record number, the specific service or supply you're requesting, and any comments, records, or other information you think is important for our review. We have the right to require that you provide all documents and information that we deem necessary to make a decision. If you don't provide any information requested in regard to any request for coverage, claim for payment, or related appeal, or if the information you provide does not show entitlement to the coverage or payment you request, this could result in an adverse decision.

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

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

EXPEDITED DECISION

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

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

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

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

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

FILING A MEDICAL MALPRACTICE CLAIM

Prior to initiating any arbitration proceedings alleging medical malpractice arising under benefit underwritten by Kaiser Foundation Health Plan, Inc. (KFHP), Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. If the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified on the next page. Note: mandatory arbitration only applies to benefits underwritten by KFHP. Member claims arising under Kaiser Permanente Insurance Company (KPIC) coverage are not subject to mandatory arbitration.

KAISER PERMANENTE BINDING ARBITRATION

A. BINDING ARBITRATION

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

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

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

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

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

(i) Kaiser Foundation Health Plan, Inc.,

(ii) Kaiser Foundation Hospitals,

(iii) Hawaii Permanente Medical Group, Inc.,

(iv) The Permanente Federation, LLC,

(v) The Permanente Company, LLC,

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

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

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

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

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

(d) for members of Groups, claims for benefits under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA); and equitable claims for third party liability lien rights under Section 502(a)(3) of ERISA.

B. INITIATING ARBITRATION

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan

at the address set forth in section 10-G of your Service Agreement. The arbitrators shall have jurisdiction only over persons and entities actually served.

C. ARBITRATION PROCEEDINGS

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

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

3. Limited civil discovery shall be permitted only for

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

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

   (c) independent medical evaluations.

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

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

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

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

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

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

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

D. GENERAL PROVISIONS

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

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

E. CONFIDENTIALITY

Your Service Agreement concerns personal medical information whose confidentiality is protected by law. Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

F. SPECIAL CLAIMS

1. Medical Malpractice Claims. Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. If the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified above.

2. ERISA Claims. If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may request external review, as discussed below, and/or file suit in federal court under Section 502(a)(1)(B) of ERISA. If a suit is filed, the court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact the plan administrator, i.e., the Member Party's employer or group sponsor.

Although benefit-related claims subject to ERISA are not required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of section 8-B above. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to this section 8.

3. External Appeal of Internal Adverse Benefit Decisions. If Member disagrees with Kaiser Permanente's final internal determination, Member shall request binding arbitration pursuant to the procedures in this Service Agreement subject to Section 8.F.2 regarding ERISA claims.

In addition to the arbitration procedures set forth in this Service Agreement, Hawaii Revised Statutes Chapter 432E also creates certain external review rights for Members of state or county employee Groups, certain employee disability or qualified church plans, and employer Groups subject to ERISA to submit a request for external review to the State Insurance Commissioner within one hundred thirty days from the date of Kaiser Permanente's final internal determination. These rights are subject to the limitations noted at the end of this subsection, and subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhaustion of Kaiser Permanente's internal claims and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals procedures is described in the Group Member Handbook. Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. An adverse action is a Health Plan determination that a health care service that is a covered benefit has been reviewed and denied, reduced or terminated because it does not meet Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. Health Plan objects to external reviews under Chapter 432E which do not meet these criteria, and reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.

YOUR RIGHTS AND RESPONSIBILITIES

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

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

YOU HAVE A RIGHT TO:

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

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

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

The patient receiving services in the Ambulatory Surgery Center may also contact Accreditation Association for Ambulatory Health Care; 5250 Old Orchard Road, Suite 200, Skokie, IL 60077. Tel: **847-853-6060**, Fax: **847-853-9028**, or by email: **info@aaahc.org**.

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

- Provide accurate and complete information about your present and past medical condition.
- Follow the treatment plan agreed to by you and your health care practitioner. You have a responsibility to inform your health care practitioner if you do not understand or cannot follow through with your treatment.
- Understand your health problems and participate in developing mutually agreed upon treatment goals, to the extent possible.
- Identify yourself appropriately and use your Kaiser Permanente identification card in accordance with Kaiser Permanente policies and procedures.
- Cooperate with our staff to help ensure proper diagnosis and treatment of your illness or condition.
- Keep your appointments, or if you cannot keep them, cancel appointments in a timely manner.
- Know your benefit coverage and its limitations.
- Cooperate in signing a release form when you choose to refuse recommended treatment or procedures.
- Realize the effects your lifestyle has on your health and understand that decisions you make in your daily life, such as smoking, can affect your health.
- Be considerate of others by respecting the rights and feelings of the staff and respecting the privacy of other patients.

- Refrain from disturbing or disrupting medical care, facility operations or administration and cooperate with staff to allow services to other patients to be performed without interruption. Conduct that is disrespectful of others, abusive (verbally or physically), or threatening will not be tolerated.
- Follow all hospital, clinic, and health plan rules and regulations, including respecting hospital visiting hours.
- Cooperate in the proper processing of third-party payments.
- Inform us when you or your covered dependents change addresses or other contact information.
- Be responsible for your actions. If you refuse treatment, or do not follow instructions it may be necessary stop attempted care temporarily, or take other appropriate action. Conduct that is disrespectful of others, abusive (verbally or physically), or threatening will not be tolerated and will result in appropriate actions and consequences.
- For Ambulatory Surgery Center (ASC) patients, provide a responsible adult to transport you home from the ASC and remain with you for 24 hours, if required by your provider.

HOSPITAL PATIENT RIGHTS

As a patient in the Moanalua Medical Center, you also have the right to:

- Receive information about your rights and responsibilities when you are admitted.
- Receive orderly transfer and discharge for your welfare, for other patients' welfare, or other causes as determined by your physician. Also, you have the right to receive reasonable advance notice and discharge planning by qualified hospital staff to help ensure appropriate post-hospital placement and care.
- Request visits by clergy at any time and participate in social and religious activities, unless doing so infringes on the rights of other patients or would compromise your medical care.
- Receive and use your own clothing and possessions as space permits, unless doing so infringes on the rights of other patients, is in violation of hospital safety practices, or would compromise your medical care.
- Give informed consent before the start of any recording, films, or other images for purposes of non-patient care.
- Access protective and advocacy services.
- Access appropriate educational services when a child or adolescent patient's treatment necessitates a significant absence from school.
- Protection from requests to perform services for Kaiser Foundation Hospital that are not included for therapeutic purposes in your plan of care.
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation as specified in federal regulations on the use of restraints and seclusion.
- Receive visitors of your choice including a spouse, (same-sex) domestic partner, family member, or friend. All or certain visits may be excluded at your request or discretion of staff, physicians, or administration to allow for your and others' rights, safety, or well-being.
- File a complaint in the hospital, either verbally or in writing, with the department manager or supervisor. If you are not satisfied with the response, you may contact Hospital Administration, which is located on the first floor of the hospital or reached through the operator at **808-432-0000.**
- You may also contact The Joint Commission (an independent, not-for-profit organization that accredits and certifies health organizations and programs) by phone, mail, fax, or email.

  Phone: toll free U.S., weekdays 8:30 a.m.–5 p.m. Central time, **1-800-994-6610**.
  Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.
  Fax: **630-792-5636**.
  Email: **complaint@jointcommission.org**

ABOUT ADDED CHOICE ENROLLMENT

THIRD-PARTY LIABILITY

Kaiser Permanente has the right to recover the cost of care for a member's injury or illness caused by another person or in an auto accident from a judgment, settlement, or other payment paid to the member by an insurance company, individual, or other third party.

ELIGIBILITY, ENROLLMENT, AND TERMINATION OF YOUR MEMBERSHIP

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

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

IF YOU BECOME ELIGIBLE FOR MEDICARE

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

There are federal regulations that mandate when Medicare will act as a secondary or primary payer in coordination with your Added Choice plan. While Medicare is your secondary payer, you may remain eligible for coverage under your Added Choice Plan. When Medicare becomes your primary payer, you will not be eligible for the Added Choice plan. Generally, Medicare is the primary payer for

- Retirees age 65 and over
- The dependent spouse of a retiree age 65 and over
- Current employee of a group with less than 20 employees
- Totally disabled dependents covered by Social Security Disability

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

KAISER PERMANENTE INSURANCE COMPANY NON-DISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
We also:

- Provide 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 **1-800-966-5955** (TTY: **711**)

If you believe that Kaiser Permanente Insurance Company 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 by mail or phone at: KPIC Civil Rights Coordinator, Grievance 1557, 5855 Copley Drive, Suite 250, San Diego, CA 92111, telephone number 1-888-251-7052.

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-966-5955** (TTY: **711**).

Cebuano (Bisaya) ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad.
Tawag sa **1-800-966-5955** (TTY: **711**).

中文 **(Chinese) 注意：**如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-966-5955**（TTY：**711**）。

Chuuk (Chukese) MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo.
Kori **1-800-966-5955** (TTY: **711**).

KPIC-NDT-17-005-HI

ʻŌlelo Hawaiʻi (Hawaiian) E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo Hawaiʻi, hiki iā ʻoe ke loaʻa i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

Iloko (Ilocano) PAKDAAR: No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka.
Awagan ti **1-800-966-5955** (TTY: **711**)

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-966-5955**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-966-5955** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-966-5955** (TTY: **711**).

Kajin Majōļ (Marshallese) LALE: Ñe kwōj kōnono Kajin Majōļ, kwomaroñ bōk jerbal in jipañ ilo kajin ņe aṃ ejjeļọk wōṇāān. Kaalọk **1-800-966-5955** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-966-5955** (TTY: **711**).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien lokaia kak sawas ni sohte isais.
Koahl nempe **1-800-966-5955** (TTY: **711**).

Faa-Samoa (Samoan) MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoani, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-800-966-5955** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-966-5955** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-966-5955** (TTY: **711**).

Lea Faka-Tonga (Tongan) FAKATOKANGA'I: Kapau ʻoku ke Lea Faka-Tonga, ko e kau tokoni fakatonu lea ʻoku nau fai atu ha tokoni ta'etotongi, pea teke lava ʻo ma'u ia. Telefoni mai **1-800-966-5955** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-966-5955** (TTY: **711**).

KAISER FOUNDATION HEALTH PLAN, INC.
NON-DISCRIMINATION NOTICE

NONDISCRIMINATION NOTICE

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

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If you believe that Kaiser 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 by mail or phone at:

Membership Services
Attn: Kaiser Civil Rights Coordinator
711 Kapiolani Blvd
Honolulu, HI 96813
1-800-966-5955

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.

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NOTES

KAISER PERMANENTE®

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

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

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

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

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