

Kaiser Permanente Group Plan Benefit and Payment Chart

34628 LACERA

About this chart

This benefit and payment chart:

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

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

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

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

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

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

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

This page is intentionally left blank

Description	Cost Share
Annual Copayment Maximum	
Member	\$2,500 per calendar year
Family Unit (3 or more members)	\$7,500 per calendar year
Annual Deductible	
Member	None
Family Unit	None
Routine and Preventive	
Health Education and Disease Management	
• Medical Office Visits	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Tobacco Cessation and Counseling Sessions	None
• Health education publications	None
• Healthy Living Classes	Applicable class fees
Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))	None
• Office visit for (CDC) Immunizations	None
• Office visit for Travel Immunization	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
Medical Office Visits	
• Well-Child Care	None
• Annual Preventive Care (physical exam)	None
• Hearing Exam (for correction)	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Vision Exam (for glasses)	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
Preventive Screenings and Care	None
Total Health Assessment (www.kp.org)	None
Special Services for Women	
Preventive Care	
• Annual Gynecological Exam	None
• Mammography (screening)	None
• Pap Smears (cervical cancer screening)	None
Family Planning Visits	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
Infertility Consultation	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
In Vitro Fertilization	20% of applicable charges
Maternity	
• Maternity Care—routine prenatal visits in Medical Office	None
• Maternity Care—delivery	None

Description	Cost Share
<ul style="list-style-type: none"> • Maternity Care—one postpartum visit in Medical Office 	None
<ul style="list-style-type: none"> • Maternity and Newborn Inpatient Stay • Breast Pump 	None
Pregnancy Termination	
<ul style="list-style-type: none"> • Primary Care • Specialty Care • Total Care Settings 	\$15 per visit \$15 per visit Included in Total Care Services
Voluntary Sterilization (including tubal ligation)	
<ul style="list-style-type: none"> • Medical Office • Total Care Settings 	None None
Special Services for Men	
Vasectomy	
<ul style="list-style-type: none"> • Primary Care • Specialty Care • Total Care Settings 	\$15 per visit \$15 per visit Included in Total Care Settings
Online Care	
My Health Manager (www.kp.org)	None
Medical Office Visits	
Medical Office Visits	
<ul style="list-style-type: none"> • Primary Care • Specialty Care • Routine pre-surgical and post-surgical 	\$15 per visit \$15 per visit None
Urgent Care Visits	
<ul style="list-style-type: none"> • Within Service Area (Primary Care) • Outside Service Area 	\$15 per visit 20% of Applicable Charges
Dependent Child Outside of Service Area	
<ul style="list-style-type: none"> • Outpatient Care • Basic laboratory and general imaging • Testing • Immunizations • Contraceptive drugs and devices • Self-administered drug prescriptions 	\$20 per visit for the first 10 visits, and 50% of Applicable Charges for additional visits \$10 per visit for the first 10 visits (combined total for laboratory, imaging, and testing), and 50% of Applicable Charges for additional visits 20% of applicable charges for the first 10 visits (combined total for laboratory, imaging, and testing), and 50% of Applicable Charges for additional visits None None 20% of applicable charges for the first 10 prescriptions, and 50% of Applicable Charges for additional prescriptions
House Calls	
<ul style="list-style-type: none"> • Primary Care • Specialty Care 	\$15 per visit \$15 per visit
Telehealth	Cost share, if applicable, will vary depending on service.

Description	Cost Share
Laboratory, Imaging, and Testing	
Laboratory	
• Basic	None
• Specialty	None
Imaging	
• Basic	None
• Specialty	None
Testing	
• Allergy Testing	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Skilled-Administered Drugs	None
• Diagnostic Testing	None
Surgery	
Outpatient Surgery and Procedures	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Total Care Settings	Included in Total Care Services
Reconstructive Surgery	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Covered Mastectomy	\$15 per visit
• Total Care Settings	Included in Total Care Services
Total Care Services	
<i>You may only pay a single Cost Share for covered benefits you receive in the following Total Care Service settings:</i>	
Inpatient Hospital Services	\$50 per day
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	\$15 per visit
Emergency Services	\$50 per visit in area, 20% of applicable charges out of area.
Observation	None
Skilled Nursing Facility	None, up to 120 days per Accumulation Period
Dialysis	
• Dialysis	10% applicable charges
• Equipment, Training and Medical Supplies for home Dialysis	None
Radiation Therapy	\$15 per visit
Ambulance	
Air Ambulance	None
Ground Ambulance	None
Physical, Occupational, and Speech Therapy	
Physical and Occupational Therapy	
• Medical Office	\$15 per visit
• Home Health Care	None
• Total Care Settings	Included in Total Care Services

Description	Cost Share
Speech Therapy	
• Medical Office	\$15 per visit
• Home Health Care	None
• Total Care Settings	Included in Total Care Services
Home Health Care and Hospice Care	
Home Health Care	None
Hospice Care	None
Physician Visits	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
Chemotherapy	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Total Care Settings	Included in Total Care Services
Internal, External Prosthetics Devices and Braces	
Implanted Internal Prosthetics, Devices and Aids	
• Medical Office	None
• Total Care Settings	Included in Total Care Services
External Prosthetics Devices	
• Outpatient	None
• Total Care Settings	Included in Total Care Services
Braces	
• Outpatient	None
• Total Care Settings	Included in Total Care Services
Durable Medical equipment	
Durable Medical equipment	
• Outpatient	No charge
• Total Care Settings	Included in Total Care Services
Oxygen (for use with DME)	
• Outpatient	None
• Total Care Settings	Included in Total Care Services
Repair or Replacement	
• Outpatient	None
• Total Care Settings	Included in Total Care Services
Diabetes Equipment	50% of Applicable Charges
Home Phototherapy equipment	None
Behavioral Health–Mental Health and Substance Abuse	
Mental Health Care	
• Medical Office	\$15 per visit
• Total Care Settings	Included in Total Care Services
Chemical Dependency Care	
• Medical Office	\$15 per visit
• Total Care Settings	Included in Total Care Services
Autism Care	
• Primary Care	\$15 per visit

Description	Cost Share
<ul style="list-style-type: none"> • Specialty Care 	\$15 per visit
Transplants	
Transplant Care for Transplant Recipients	
<ul style="list-style-type: none"> • Primary Care • Specialty Care • Total Care Settings 	\$15 per visit \$15 per visit Included in Total Care Services
Transplant Care for Transplant Donors (based on health plan approval)	
<ul style="list-style-type: none"> • Primary Care • Specialty Care • Total Care Settings 	\$15 per visit \$15 per visit Included in Total Care Services
<ul style="list-style-type: none"> • Related Prescription Drugs 	See prescription drugs in this <i>Benefit Summary</i>
Transplant Evaluations	
<ul style="list-style-type: none"> • Primary Care • Specialty Care 	\$15 per visit \$15 per visit
Prescription Drug	
Skilled Administered Drugs	None (included in Total Care Services)
Self-Administered Drugs	If your employer has purchased a drug rider, coverage will be as specified in your drug rider following this <i>Benefit Summary</i>
Chemotherapy Drugs	
<ul style="list-style-type: none"> • Chemotherapy Infusion or Injections (Skilled Administered Drugs) • Chemotherapy–Oral Drugs (Self-Administered Drugs) 	None None or as specified in applicable drug rider
Contraceptive Drugs and Devices	50% of applicable charges or None
Diabetic Supplies	50% of Applicable Charges
Tobacco Cessation Drugs and Products	None (up to 30-day supply)
Drug Therapy Care	
Growth Hormone Therapy	
<ul style="list-style-type: none"> • Primary Care • Specialty Care • Skilled-Administered Drug • Total Care Settings 	\$15 per visit \$15 per visit None Included in Total Care Services
Home IV/Infusion therapy	
<ul style="list-style-type: none"> • Therapy and IV drugs • Self-Administered Injections 	None See prescription drugs in this <i>Benefit Summary</i>
Inhalation Therapy	
<ul style="list-style-type: none"> • Primary Care • Specialty Care • Total Care Settings 	\$15 per visit \$15 per visit Included in Total Care Services
Miscellaneous Medical Treatments	
Blood and Blood Products	
<ul style="list-style-type: none"> • Medical Office • Rh Immune Globulin • Total Care Settings 	None None Included in Total Care Services

Description	Cost Share
Dental Procedures for Children	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Total Care Settings	Included in Total Care Services
Hearing Aids	
• Hearing Test	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Appliances	60% of Applicable Charges
Hyperbaric Oxygen Therapy	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Total Care Settings	Included in Total Care Services
Materials for Dressings and Casts	Cost Share will vary upon place of service
• Total Care Settings	Included in Total Care Services
Medical Foods	20% of Applicable Charges
Medical Social Services	None
Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
Rehabilitation Services	
• Primary Care	\$15 per visit
• Specialty Care	\$15 per visit
• Total Care Settings	Included in Total Care Services

Description	Cost Share
Additional services	
Prescribed Drugs, Self-Administered \$10 per prescription	Prescription drug 10
Special Services for Women Artificial insemination (intrauterine insemination)	Same infertility cost share listed in the <i>Benefit Summary</i> in the front of this Guide
Optical services	Not included
Dental services	Not included
Complementary Alternative Medicine	Not included
Fit Rewards (per calendar year)	\$200 gym membership or \$10 home fitness program