Kaiser Permanente Group Plan 220
Benefit and Payment Chart

10890 BROWN & BROWN

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.

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
•Maternity Care–one postpartum visit in Medical Office	None
•Maternity and Newborn Inpatient Stay	None
•Breast Pump	None
Pregnancy Termination	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
Voluntary Sterilization (including tubal ligation)	
•Medical Office	None
•Total Care Settings	None
Special Services for Men	
Vasectomy	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Settings
Online Care	
My Health Manager (www.kp.org)	None
Medical Office Visits	
Medical Office Visits	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Routine pre-surgical and post-surgical	None
Office visits for children through age 17	
• Primary care	None
• Specialty care	$15 per visit
Urgent Care Visits	
•Within Service Area (Primary Care)	$15 per visit
•Outside Service Area	20% of Applicable Charges
Dependent Child Outside of Service Area	
• Outpatient Care	$20 per visit for the first 10 visits, and 50% of Applicable Charges for additional visits
• Basic laboratory and general imaging	$10 per visit for the first 10 visits (combined total for laboratory, imaging, and testing), and 50% of Applicable Charges for additional visits
• Testing	20% of applicable charges for the first 10 visits (combined total for laboratory, imaging, and testing), and 50% of Applicable Charges for additional visits
• Immunizations	None
• Contraceptive drugs and devices	None
• Self-administered drug prescriptions	20% of applicable charges for the first 10 prescriptions, and 50% of Applicable Charges for additional prescriptions
House Calls	
•Primary Care	$15 per visit

Description	Cost Share
•Specialty Care	$15 per visit
Telehealth	Cost Share, if applicable, will vary depending on service.

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

Description	Cost Share
•Total Care Settings	Included in Total Care Services
Speech Therapy	
•Primary Care	$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	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Braces	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Durable Medical equipment	
Durable Medical equipment	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Oxygen (for use with DME)	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Repair or Replacement	
•Outpatient	20% of applicable charges
•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

Description	Cost Share
Autism Care	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
Transplants	
Transplant Care for Transplant Recipients	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
Transplant Care for Transplant Donors (based on health plan approval)	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
•Related Prescription Drugs	See prescription drugs in this *Benefit Summary*
Transplant Evaluations	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
Prescription Drug	
Skilled Administered Drugs	20% of applicable charges, (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 Benefit Summary*
Chemotherapy Drugs	
•Chemotherapy Infusion or Injections (Skilled Administered Drugs)	20% of applicable charges
•Chemotherapy–Oral Drugs (Self-Administered Drugs)	20% of applicable charges, 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	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Skilled-Administered Drug	20% of applicable charges
•Total Care Settings	Included in Total Care Services
Home IV/Infusion therapy	
•Therapy and IV drugs	None
•Self-Administered Injections	See prescription drugs in this *Benefit Summary*
Inhalation Therapy	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
Miscellaneous Medical Treatments	
Blood and Blood Products	
•Medical Office	None

Description	Cost Share
•Rh Immune Globulin	20% of applicable charges
•Total Care Settings	Included in Total Care Services
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	20% 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 Generic Maintenance Drugs: $3 per prescription Other Generic Drugs: $10 per prescription Brand-Name Drugs: $45 per prescription Specialty drugs: $200	**4-Tier Prescription drug 3/10/45/200**
Prescription drug mail-order incentive	Two drug copayments for a 90-consecutive-day supply
Special Services for Women Artificial insemination (intrauterine insemination)	Same infertility cost share listed in the *Benefit Summary* in the front of this Guide
Optical $150	Allowance for glasses or contacts: All costs greater than $150 allowance per Accumulation Period
Dental services	Not included
Complementary Alternative Medicine	Not included
Fit Rewards (per calendar year)	$200 gym membership or $10 home fitness program