Kaiser Permanente Group Plan 401

Benefit and Payment Chart

WSP USA INC

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.

Annual Copayment Maximum Member \$2,500 per calendar year Family Unit (3 or more members) \$7,500 per calendar year Annual Deductible None per calendar year Member None per calendar year Family Unit (3 or more members) None Routine and Preventive Health Education and Disease Management • Medical Office Visits \$15 per visit • Specialty Care \$15 per visit • Tobacco Cessation and Counseling Sessions None • Health education publications None • Disease Control and Prevention (CDC)) • Office visit for (CDC) Immunizations None • Office visit for (CDC) Immunizations None \$15 per visit • Specialty Care \$15 per visit \$15 per visit • Office visit for Correction) • Office Visits None • Well-Child Care None \$15 per visit • Specialty Care \$15 per visit \$15 per visit • Specialty Care \$15 per visit \$15 per visit • Specialty Care \$15 per visit \$15 per visit • Primary Care \$15 per visit \$15 per visit • Specialty Care \$15 per visit	Description	Cost Share
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		Nono
		None

Description	Cost Share
Maternity Care–one postpartum visit in Medical	None
Office	
 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
Urgent Care Visits	None
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
0	(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
• Specialty Care	\$15 per visit
Telehealth	Cost share, if applicable, will vary depending on
	service.

Description	Cost Share
Laboratory, Imaging, and Testing	
Laboratory	
• Basic	10% of applicable charges
• Specialty	10% of applicable charges
Imaging	
• Basic	10% of applicable charges
• Specialty	10% 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 	10% 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 	\$15 per visit
 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	\$75 per day
Outpatient Surgery and Procedures in a Hospital-	\$15 per visit
Based Setting or Ambulatory Surgery Center (ASC)	
Emergency Services	\$75 per visit in area, \$75 per visit out of area.
Observation	None
Skilled Nursing Facility	None, up to 120 days per Accumulation Period
Dialysis	
Dialysis	20% applicable charges
 Equipment, Training and Medical Supplies 	None
for home Dialysis	
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
Total Care Settings	Included in Total Care Services

Description	Cost Share
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	Included III Total Care Services
Outpatient	20% of applicable charges
Total Care Settings	Included in Total Care Services
Braces	Included III Total Care Services
Outpatient	20% of applicable charges
Total Care Settings	Included in Total Care Services
	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	200% of employed to the second
• Outpatient	20% of applicable charges
Total Care Settings	Included in Total Care Services
Diabetes Equipment Home Phototherapy equipment	50% of Applicable Charges None
	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	* 1 - • •
Medical Office	\$15 per visit
Total Care Settings	Included in Total Care Services
Autism Care	* 1 - • •
Primary Care	\$15 per visit

Description	Cost Share
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,
5	(included in Total Care Services)
Self-Administered Drugs	If your employer has purchased a drug rider,
5	coverage will be as specified in your drug
	rider following this Benefit Summary
Chemotherapy Drugs	<u> </u>
 Chemotherapy Infusion or Injections 	20% of applicable charges
(Skilled Administered Drugs)	
Chemotherapy–Oral Drugs	20% of applicable charges, or as specified
(Self-Administered Drugs)	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
Rh Immune Globulin	20% of applicable charges
 Total Care Settings 	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	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 Orofac	cial
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	4-Tier Prescription drug
	3/10/45/200
Generic Maintenance Drugs: \$3 per prescription	
Other Generic Drugs: \$10 per prescription	
Brand-Name Drugs: \$45 per prescription	
Specialty drugs: \$200	
Prescription drug	Two drug copayments
mail-order incentive	for a 90-consecutive-day supply
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