

Kaiser Permanente Added Choice 306 Benefit and Payment Chart

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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 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, In-Network services and other In-Network 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.

Insurance benefits for certain medical and hospital services not covered by Health Plan (Out-of-Network Services) are offered through a separate insurance policy issued along with the Group Agreement by Kaiser Permanente Insurance Company (KPIC). The Out-of-Network Services are described in the KPIC Group Policy and Certificate of Insurance.

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Description	In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
		Contracted Provider Cost Share	Non-Contracted Provider Cost Share
Annual Copayment			
Maximum			
Member	\$2,000 per calendar year	\$2,000 per calendar year	
Family Unit	\$6,000 per calendar year	\$6,000 per calendar year (for 3 or more members)	
Annual Deductible			
Member	None	\$100 per calendar year	
Family Unit	None	\$300 per calendar year (for 3 or more members)	
Routine and Preventive			
Health Education and Disease Man- agement			
• Medical Office Visits			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Tobacco Cessation and Counseling Sessions	None	No Charge up to the MAC*, deductible waived (if your group purchased a drug rider)	No charge up to the MAC*, deductible waived
• Health education publications	None	20% of the MAC*, limited to diabetes training	20% of the MAC*, limited to diabetes training
• Healthy Living Classes	Applicable class fees	No charge up to the MAC*, deductible waived, limited to ACA Health Promotion	
Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))	None	No charge up to the MAC*, deductible waived	
• Office visit for (CDC) Immunizations	None	No charge up to the MAC*, deductible waived	
• Office visit for Travel Immunization			
• Primary Care	\$20 per visit	Not covered	Not covered
• Specialty Care	\$20 per visit	Not covered	Not covered
Medical Office Visits			
• Well-Child Care (birth through age 5)	None	20% of the MAC*, deductible waived	
• Well-Child Care (age 6 through 19)	None	20% of the MAC*	20% of the MAC*
• Annual Preventive Care (physical exam)	None	20% of the MAC*	20% of the MAC*
• Hearing Exam (for correction)			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*

Description		In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
			Contracted Provider Cost Share	Non-Contracted Provider Cost Share
● Vision Exam (for glasses)				
● Primary Care		\$20 per visit	20% of the MAC*	20% of the MAC*
● Specialty Care		\$20 per visit	20% of the MAC*	20% of the MAC*
Preventive Screenings and Care		None	PPACA: No charge up to the MAC*, deductible waived Non-PPACA: 20% up to the MAC*	
Total	Health	Assessment	None	Not Applicable
(www.kp.org)				Not Applicable
Special Services for Women				
Preventive Care				
● Annual Gynecological Exam		None	See Preventive Screenings and Care in this <i>Benefit Summary</i>	
● Mammography (screening)		None	See Preventive Screenings and Care in this <i>Benefit Summary</i>	
● Pap Smears (cervical cancer screening)		None	See Preventive Screenings and Care in this <i>Benefit Summary</i>	
Family Planning Visits				
● Primary Care		\$20 per visit	20% of the MAC*	20% of the MAC*
● Specialty Care		\$20 per visit	20% of the MAC*	20% of the MAC*
Infertility Consultation				
● Primary Care		\$20 per visit	20% of the MAC*	20% of the MAC*
● Specialty Care		\$20 per visit	20% of the MAC*	20% of the MAC*
In Vitro Fertilization		20% of Applicable Charges	20% of the MAC*	20% of the MAC*
Maternity				
● Maternity Care--routine prenatal visits in Medical Office		None	No charge up to the MAC*, deductible waived	
● Maternity Care--delivery		10% of Applicable Charges	20% of the MAC*	20% of the MAC*
● Maternity Care--postpartum visits in Medical Office		None	No charge up to the MAC*, deductible waived	
● Maternity and Newborn Inpatient Stay		10% of Applicable Charges	20% of the MAC*	20% of the MAC*
● Breast Pump		None	No charge up to the MAC*, deductible waived	
Pregnancy Termination				
● Primary Care		\$20 per visit	20% of the MAC*	20% of the MAC*
● Specialty Care		\$20 per visit	20% of the MAC*	20% of the MAC*
● Total Care Settings		Included in Total Care Services	N/A	N/A
Voluntary Sterilization (including tubal ligation)				
● Medical Office		None	20% of the MAC*	20% of the MAC*
● Total Care Settings		None	N/A	N/A

Description	In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
		Contracted Provider Cost Share	Non-Contracted Provider Cost Share
Special Services for Men			
Vasectomy			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Settings	N/A	N/A
Online Care			
My Health Manager (www.kp.org)	None	N/A	N/A
Medical Office Visits			
Medical Office Visits			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Routine pre-surgical and post-surgical	None	20% of the MAC*	20% of the MAC*
Urgent Care Visits			
• Within Service Area (Primary Care)	\$20 per visit	Covered in-Network	Covered in-Network
• Outside Service Area	20% of Applicable Charges	Covered in-Network	20% of the MAC*
Prescription Drug Coverage Outside the Services Area			
• Self-Administered Drugs	20% of Applicable Charges	Not Covered	Not Covered
House Calls			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
Telehealth	Cost share, if applicable, will vary depending on Service	20% of the MAC*	20% of the MAC*
Laboratory, Imaging, and Testing			
Laboratory			
• Basic	\$10 per day	20% of the MAC*	20% of the MAC*
• Specialty	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
Imaging			
• General	\$10 per day	20% of the MAC*	20% of the MAC*
• Specialty	20% of Applicable Charges	20% of the MAC*	20% of the MAC*

Description	In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
		Contracted Provider Cost Share	Non-Contracted Provider Cost Share
Testing			
Allergy Testing			
• Testing			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Skilled-Administered Drugs	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Diagnostic Testing	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
Surgery			
Outpatient Surgery and Procedures			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Total Care Services	Included in Total Care Services	N/A	N/A
Reconstructive Surgery			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Covered Mastectomy	10% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Total Care Services			
<i>You may only pay a single Cost Share for covered benefits you re- ceive in the following Total Care Ser- vice settings:</i>			
Inpatient Hospital Services	10% of Applicable Charges	20% of the MAC*	20% of the MAC*
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	10% of Applicable Charges	20% of the MAC*	20% of the MAC*
Emergency Services	\$100 per visit	Covered in-Network	Covered in-Network
Observation	10% of Applicable Charges	20% of the MAC*	20% of the MAC*
Skilled Nursing Facility	10% of Applicable Charges for up to 120 days per Accumulation Period	20% of the MAC*, for up to 120 days per Accumulation Period	

Description	In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
		Contracted Provider Cost Share	Non-Contracted Provider Cost Share
Dialysis			
• Dialysis	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Equipment, Training and Medical Supplies for home Dialysis	None	20% of the MAC*	20% of the MAC*
Radiation Therapy	20% of Applicable charges	20% of the MAC*	20% of the MAC*
Ambulance			
Air Ambulance	20% of Applicable Charges	20% of the MAC* for scheduled transportation to or from an acute care hospital or skilled nursing facility where treatment is being rendered	
Ground Ambulance	20% of Applicable Charges	20% of the MAC* for scheduled transportation to or from an acute care hospital or skilled nursing facility where treatment is being rendered	
Physical, Occupational, and Speech Therapy			
Physical and Occupational Therapy			
• Medical Office	\$20 per visit	20% of the MAC*	
• Home Health Care	None	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total care Ser- vices	N/A	N/A
Speech Therapy			
• Medical Office	\$20 per visit	20% of the MAC*	20% of the MAC*
• Home Health Care	None	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Home Health Care and Hospice Care			
Home Health Care	None	20% of the MAC* limited to a combined maximum of 150 visits per calendar year	
Hospice Care	None	20% of the MAC* limited to a combined maximum of 210 days while insured	
Physician Visits			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*

Description	In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
		Contracted Provider Cost Share	Non-Contracted Provider Cost Share
Chemotherapy Services			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Internal, External Prosthetics Devices and Braces			
Implanted Internal Prosthetics, De- vices and Aids			
• Medical Office	None	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
External Prosthetics Devices			
• Outpatient	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Braces			
• Outpatient	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Durable Medical Equipment			
Durable Medical Equipment			
• Outpatient	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Oxygen (for use with DME)			
• Outpatient	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Repair or Replacement			
• Outpatient	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Diabetes Equipment	50% of applicable charges	20% of the MAC*	20% of the MAC*
Home Phototherapy equipment	None	20% of the MAC*	20% of the MAC*

Description	In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
		Contracted Provider Cost Share	Non-Contracted Provider Cost Share
Behavioral Health, Mental Health and Substance Abuse			
Mental Health Care			
• Medical Office	\$20 per visit	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Chemical Dependency Care			
• Medical Office	\$20 per visit	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Autism Care			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
Transplants			
Transplant Care for Transplant Recipients			
• Primary Care	\$20 per visit	20% of the MAC*, limited to Corneal and Kidney Transplants, Other Transplant Services Covered in-Network	20% of the MAC*, limited to Corneal and Kidney Transplants, Other Transplant Services Covered in-Network
• Specialty Care	\$20 per visit	20% of the MAC*, limited to Corneal and Kidney Transplants, Other Transplant Services Covered in-Network	20% of the MAC*, limited to Corneal and Kidney Transplants, Other Transplant Services Covered in-Network
• Total Care Settings	Included in Total Care Services	N/A	N/A
Transplant Care for Transplant Donors (based on health plan approval)			
• Primary Care	\$20 per visit	Covered in-Network	Covered in-Network
• Specialty Care	\$20 per visit	Covered in-Network	Covered in-Network
• Total Care Settings	Included in Total Care Services	N/A	N/A
• Related Prescription Drugs	See prescription drugs in this <i>Benefit Summary</i>	Covered in-Network	Covered in-Network
Transplant Evaluations			
• Primary Care	\$20 per visit	Covered in-Network	Covered in-Network
• Specialty Care	\$20 per visit	Covered in-Network	Covered in-Network

Description	In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
		Contracted Provider Cost Share	Non-Contracted Provider Cost Share
Prescription Drug			
Skilled Administered Drugs	20% of Applicable Charges (included in Total Care Services)	20% of the MAC*	20% of the MAC*
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			
• Chemotherapy Infusion or Injections (Skilled Administered Drugs)	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Chemotherapy--Oral Drugs (Self-Administered Drugs)	20% of Applicable Charges or as specified in applicable drug rider	20% of the MAC*	20% of the MAC*
Contraceptive Drugs and Devices	50% of Applicable Charges or None	No charge up to the MAC*, deductible waived	No charge up to the MAC*, deductible waived
Diabetic Supplies	50% of Applicable Charges	20% of the MAC*	20% of the MAC*
Tobacco Cessation Drugs and Products	None (up to 30-day supply)	Not covered	Not covered
Drug Therapy Care			
Growth Hormone Therapy			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Skilled-Administered Drug	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Home IV/Infusion therapy			
• Therapy and IV drugs	None	20% of the MAC*	20% of the MAC*
• Self-Administered Drugs	See prescription drugs in this <i>Benefit Summary</i>	See prescription drugs in this <i>Benefit Summary</i>	See prescription drugs in this <i>Benefit Summary</i>
Inhalation Therapy			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Miscellaneous Medical Treatments			
Blood and Blood Products			
• Medical Office	None	20% of the MAC*	20% of the MAC*
• Rh Immune Globulin	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A

Description	In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
		Contracted Provider Cost Share	Non-Contracted Provider Cost Share
Dental Procedures for Children			
• Primary Care	\$20 per visit	Not covered	Not covered
• Specialty Care	\$20 per visit	Not covered	Not covered
• Total Care Settings	Included in Total Care Services	N/A	N/A
Hearing Aids			
• Hearing Test			
• Primary Care	\$20 per visit	Not covered	Not covered
• Specialty Care	\$20 per visit	Not covered	Not covered
• Appliances	20% of Applicable Charges	Not covered	Not covered
Hyperbaric Oxygen Therapy			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A
Materials for Dressings and Casts			
• Total Care Settings	Cost Share will vary upon place of service Included in Total Care Services	N/A	N/A
Medical Foods			
	20% of Applicable Charges	20% of the MAC*	20% of the MAC*
Medical Social Services			
	None	Not Covered	Not Covered
Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
Rehabilitation Services			
• Primary Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	\$20 per visit	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total Care Services	N/A	N/A

Additional services

Description	In-Network Kaiser Permanente Cost Share	Out-of-Network ¹ Kaiser Permanente Insurance Company	
		Contracted Provider Cost Share	Non-Contracted Provider Cost Share
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	20% of charge but not less than stated copay value per prescription of each given category (limited to 30 day supply per prescrip- tion)	Not covered
Prescription drug mail-order incentive	Two drug copayments for a 90-consecutive-day supply	N/A	N/A
Artificial Insemination	Included		
Optical \$150	Allowance for glasses or contacts: All costs greater than \$150 allowance per Accumu- lation Period	\$50 hardware allowance	\$50 hardware allowance
Dental services Hawaii Dental Services (HDS) Rider 1801	Plan Pays (Provided by Hawaii Dental Services (HDS) participating dentist) Exam (twice per calendar year): 100% of Allowed Amount Bitewing X-rays (twice 0-18, once 19+ per calendar year): 100% of Allowed Amount Cleaning (twice per calendar year): 100% of Allowed Amount Restorative: 70% of Allowed Amount Prosthodontics and crowns: 50% of allowed amount An HDS member out-of-pocket costs may be higher if visiting a non-participating HDS dentist.		
Complementary Alternative Medicine Chiropractic and acupuncture ser- vices (up to 20 visits per calendar year)	\$15 per visit		
Fit Rewards (per calendar year)	\$200 gym membership or \$0 home fitness program		

*Out-of-Network benefit payments are based on the Maximum Allowable Charge (MAC). The MAC is the lesser of (1) the usual and customary charge; (2) the negotiated rate; or (3) the actual billed charges. In addition to any coinsurance amounts, a member is responsible for charges which exceed the MAC. Please see the Group policy for the exception that applies for emergency services rendered by non-contracted providers.

¹Kaiser Permanente Insurance Company (KPIC) underwrites the Out-of-Network coverage. For details about the terms of coverage, including exclusions and limitations, please refer to the applicable KPIC Group Policy and Certificate of Insurance (COI).