Kaiser Permanente Added Choice 405 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 Management			
• Medical Office Visits			
• Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 per visit	20% of the MAC*	20% of the MAC*
• Tobacco Cessation and Counseling Sessions	None	No Charge up to the MAC*	No charge up to the MAC*
• 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	$15 per visit	Not covered	Not covered
• Specialty Care	$15 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	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 per visit	20% of the MAC*	20% of the MAC*
• Vision Exam (for glasses)			
• Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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
Preventive Screenings and Care	None	PPACA: No charge up to the MAC*, deductible waived Non-PPACA: 20% up to the MAC*	
Total Health Assessment (www.kp.org)	None	Not Applicable	Not Applicable
Special Services for Women			
Preventive Care			
• Annual Gynecological Exam	None	20% of the MAC*, deductible waived	
• Mammography (screening)	None	20% of the MAC*, deductible waived	
• Pap Smears (cervical cancer screening)	None	20% of the MAC*, deductible waived	
Family Planning Visits			
• Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 per visit	20% of the MAC*	20% of the MAC*
Infertility Consultation			
• Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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*	No charge up to the MAC*
• Maternity Care--delivery	None	20% of the MAC*	20% of the MAC*
• Maternity Care--one postpartum visit in Medical Office	None	No Charge up to the MAC*	No charge up to the MAC*
• Maternity and Newborn Inpatient Stay	None	20% of the MAC*	20% of the MAC*
• Breast Pump	None	No charge up to the MAC*, deductible waived	
Pregnancy Termination			
• Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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)	$15 per visit	Covered in-Network	Covered in-Network
• Outside Service Area	20% of Applicable Charges	20% of the MAC*	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	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Specialty	10% of Applicable Charges	20% of the MAC*	20% of the MAC*
Imaging			
• General	10% of Applicable Charges	20% of the MAC*	20% of the MAC*
• Specialty	10% 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	$15 per visit	20% of the MAC*	20% of the MAC*
● Specialty Care	$15 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	10% of Applicable Charges	20% of the MAC*	20% of the MAC*
Surgery			
Outpatient Surgery and Procedures			
● Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
● Specialty Care	$15 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	$15 per visit	20% of the MAC*	20% of the MAC*
● Specialty Care	$15 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			
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	20% of the MAC*	20% of the MAC*
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	$15 per visit	20% of the MAC*	20% of the MAC*
Emergency Services	$75	Covered in-Network	Covered in-Network
Observation	None	20% of the MAC*	20% of the MAC*
Skilled Nursing Facility	None	20% of the MAC*, for up to 120 days	

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	$15 per visit	20% of the MAC* limited to a combined (physical, occupational, and speech therapy) maximum 60 outpatient visits per year	
• Home Health Care	None	20% of the MAC*	20% of the MAC*
• Total Care Settings	Included in Total care Services	N/A	N/A
Speech Therapy			
• Medical Office	$15 per visit	20% of the MAC* limited to a combined (physical, occupational, and speech therapy) maximum 60 outpatient visits per year	
• 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	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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			
• Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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, Devices and Aids			
• Medical Office	$15 per visit	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	$15 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	$15 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	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 per visit	20% of the MAC*	20% of the MAC*
Transplants			
Transplant Care for Transplant Recipients			
• Primary Care	$15 per visit	Covered in-Network	Covered in-Network
• Specialty Care	$15 per visit	Covered in-Network	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	$15 per visit	Covered in-Network	Covered in-Network
• Specialty Care	$15 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 *Benefit Summary*	Covered in-Network	Covered in-Network
Transplant Evaluations			
• Primary Care	$15 per visit	Covered in-Network	Covered in-Network
• Specialty Care	$15 per visit	Covered in-Network	Covered in-Network
Prescription Drug			
Skilled Administered Drugs	20% of Applicable Charges (included in Total Care Services)	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
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	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	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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 *Benefit Summary*	See prescription drugs in this *Benefit Summary*	See prescription drugs in this *Benefit Summary*
Inhalation Therapy			
• Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
• Specialty Care	$15 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	$15 per visit	Not covered	Not covered
● Specialty Care	$15 per visit	Not covered	Not covered
● Total Care Settings	Included in Total Care Services	N/A	N/A
Hearing Aids			
● Hearing Test			
● Primary Care	$15 per visit	Not covered	Not covered
● Specialty Care	$15 per visit	Not covered	Not covered
● Appliances	20% of Applicable Charges	Not covered	Not covered
Hyperbaric Oxygen Therapy			
● Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
● Specialty Care	$15 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	Cost Share will vary upon place of service	20% of the MAC*	20% of the MAC*
● Total Care Settings	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	$15 per visit	20% of the MAC* limited to $6,898 per treatment phase	20% of the MAC* limited to $6,898 per treatment phase
● Specialty Care	$15 per visit	20% of the MAC* limited to $6,898 per treatment phase	20% of the MAC* limited to $6,898 per treatment phase
Rehabilitation Services			
● Primary Care	$15 per visit	20% of the MAC*	20% of the MAC*
● Specialty Care	$15 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 3/15/50/200** Generic Maintenance Drugs: $3 per prescription Other Generic Drugs: $15 per prescription Brand-Name Drugs: $50 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 prescription)	Not covered
Prescription drug mail-order incentive	Two drug copayments for a 90-consecutive-day supply	N/A	N/A
Optical services	Not included		
Dental services	Not included		
Complementary Alternative Medicine **Chiropractic, acupuncture, and massage therapy services** (up to 20 visits per calendar year)	(Provided by American Specialty Health Services) $20 per visit		
Fit Rewards (per calendar year)	(Provided by American Specialty Health Services) $200 gym membership or $10 home fitness program		