KAISER PERMANENTE®

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2018 Features of your Kaiser Permanente Group Plan

This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, benefit schedule, and riders (collectively known as "Service Agreement"

Section	Benefits	You Pay
Supplemental charges maximum**	Your copays and coinsurance for covered Basic Health Services are capped by a **supplemental charges maximum**	$2,500 / $7,500
Deductible	Deductible**	None
Outpatient services	**Office visits****	
	• For primary care	$20 per visit
	• With a Specialist	$20 per visit
	Outpatient surgery and procedures	
	• Provided in medical office during a primary care visit	$20 per visit
	• Provided in medical office with a Specialist	$20 per visit
	• Provided in an ambulatory surgery center (ASC) or hospital-based setting	10% of applicable charges
	• Routine pre- and post-surgical office visits in connection with a covered surgery	No charge
Outpatient laboratory, imaging, and testing services	**Laboratory services****	$10 copay per department per day
	Imaging services**	
	• General radiology	$10 copay per department per day
	• Specialty imaging services	20% of applicable charges
	Testing services**	20% of applicable charges
Preventive care services	**Preventive care office visits for:** • Well child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, and 5 years) • Routine immunizations • One preventive care office visit per accumulation period for members 6 years of age and over • One gynecological office visit per accumulation period for female members	No charge
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 (Applies towards the annual supplemental charges maximum per calendar year)
	Prescribed drugs that require skilled administration by medical personnel, such as injections and infusions (e.g. cannot be self-administered)**	

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Section	Benefits	You Pay
	• Provided in a medical office▼	20% of applicable charges
	• Provided during other settings, such as hospital stay, outpatient surgery, skilled nursing care	Applicable cost shares apply. See applicable benefit sections†
	Diabetes supplies**	50% of applicable charges (a minimum price as determined by Pharmacy Administration may apply)
	Tobacco cessation drugs and products**	No charge
	Other drug therapy services	
	• Home IV/Infusion therapy**	No charge
	• Medically necessary growth hormone therapy	Applicable cost shares apply.
	• Prescribed inhalation therapy	See applicable benefit sections†
	Routine immunizations	No charge
Obstetrical Care	Routine prenatal visits	No charge
	Routine postpartum visit	No charge
	Delivery/hospital stay (uncomplicated)	10% of applicable charges
Hospital Inpatient care	Hospital inpatient care	10% of applicable charges
Home health care and hospice care	**Home health care**, nurse and home health aide visits to homebound members, when prescribed by a Kaiser Permanente physician	No charge (office visit copays apply to physician visits)
	Hospice care**	No charge (office visit copays apply to physician visits)
Emergency services	**Emergency services**** within and outside the Hawaii service area *Note: The copayment for emergency services is waived if you are directly admitted as a hospital inpatient from the emergency department (the hospital copay will apply)*	$100 per visit / $100 per visit
Urgent care services	**Urgent care services****	
	• At a Kaiser Permanente (or Kaiser Permanente-designated) urgent care center within the Hawaii service area, for primary care services	$20 per visit
	• At a non-Kaiser Permanente facility outside the Hawaii service area	20% of applicable charges
Ambulance services	Ambulance services**	20% of applicable charges
Durable medical equipment**	**Diabetes equipment**	50% of applicable charges
	Home phototherapy equipment for newborns	No charge
	Breast feeding pump, including any equipment that is required for pump functionality	No charge
	All other **durable medical equipment**	20% of applicable charges
External prosthetic devices and braces**	**External prosthetic devices and braces**	20% of applicable charges

Section	Benefits	You Pay
	Additional services	
Prescription drug mail-order incentive		Two drug copayments for a 90-consecutive-day supply
Fit Rewards	per calendar year	$200 gym membership or $10 home fitness program

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