The Evidence of Coverage (EOC) is the legally binding contract between Kaiser Permanente Health Plan and its members. The EOC includes the Kaiser Permanente Hawaii's Guide to your Health Plan, your employer’s Group Agreement, riders, and amendments, if any. In the event of ambiguity, or a conflict between this summary and the EOC, the EOC shall control.

Please note that this summary does not fully describe your coverage. For details on your coverage, please refer to your Kaiser Permanente Hawaii’s Guide to Your Health Plan (Guide). This summary does not apply to Added Choice out-of-network coverage, Kaiser Permanente for Individuals and Families, Federal, State, Medicaid or Medicare members.

For specific questions about benefits, you may call our Customer Service Center at 1-800-966-5955.

Your employer may have purchased benefits (referred to as “riders”) that override some of these changes. However, riders are not available for some of the changes described below.

Under the Patient Protection and Affordable Care Act (PPACA), your coverage may be considered a “grandfathered plan.” Some of the benefit changes below may not be applicable to a grandfathered plan.

**CONTRACT CHANGES:**
These changes become effective on your employer’s contract renewal date, unless specified otherwise below.

1. **Routine newborn nursery care.** All newborns will be covered for routine newborn nursery care services for the first 48 or 96 hours after birth. (Previously, routine newborn nursery care services were covered only when the newborn is enrolled.)

2. **Artificial insemination.** Artificial insemination (intrauterine insemination) will no longer be covered as a stand-alone fertility treatment. Artificial insemination will be a medically necessary procedure under the in vitro fertilization (IVF) benefit. (Previously, artificial insemination was an independent clause not placed with IVF benefit.)

If your plan is KP Gold $15, KP Gold $17, or KP Gold I $20, see also “Plan-Specific Cost Share Changes” section on the next page.

**REORGANIZED CONTENT**

The content is reorganized in the new Guide and language may appear different (from the former format of benefit summary, Benefit Schedule and Service Agreement). The meaning and intent continue to be the same. Examples:

1. **Total Care Services.** In 2016, KP implemented benefits which are covered with a single Cost Share. Our Guide defines these benefits as Total Care Services, and organizes them into one section. When a member receives a covered benefit in a Total Care Service setting, member only pays a single Cost Share. The seven Total Care Service settings are inpatient Hospital, outpatient surgery and procedures in a hospital-based setting or ambulatory surgery center (ASC), Emergency, observation, Skilled Nursing Facility, dialysis, and radiation therapy. (Previously, the single Cost Share was not clearly described in the multiple sections of the benefit summary and Benefit Schedule.)

2. **Preventive screenings and care.** Our Guide organizes the various preventive screenings and care into one section. (Previously, the screenings and care were described in multiple sections of the benefit summary and Benefit Schedule.)

3. **Special services for women.** Our Guide features the special services for women in one section. This section includes annual gynecological, screenings, family planning infertility consultation, in vitro fertilization, maternity, pregnancy termination and sterilization. (Previously, these services were described in multiple sections of the benefit summary and Benefit Schedule.)

4. **Benefit and payment chart.** A benefit and Cost Share payment chart is conveniently located in the front of our Guide. The member's benefits and Cost Share are easy to find in this chart, and includes a page number for more
information in Chapter 3 in our Guide. Chapter 3: Benefit Description contains the corresponding benefit descriptions and details. (Previously, Cost Shares were listed within benefit descriptions, which are described throughout the benefit summary and Benefit Schedule.)

5. **Services not covered.** The exclusions are located within Chapter 4: Services Not Covered. (Previously, exclusions were listed for specific benefits in the Benefit Schedule, and general exclusions for all benefits were listed in the Service Agreement.)

**PLAN SPECIFIC COST SHARE CHANGES**

These changes become effective on your employer’s contract renewal date, unless specified otherwise below.

**KP Gold $15 Plan**

- Annual copayment maximum for medical services will be $2,500 per member/$5,000 for a family of 2 or more members (was $2,200/$4,400).
- Annual deductible for medical services will be $250 per member/$500 for a family of 2 or more members (was $200/$400).
- Annual prescription drug copayment maximum (on pharmacy dispensed drugs) will be $5,400 per member/$10,800 for a family of 2 or more members (was $5,150/$10,300).
- Annual prescription drug deductible for brand and specialty drugs will be $700 per member/$1,400 for a family of 2 or more members (was $500/$1,000).

**KP Gold $17 Plan**

- Annual prescription drug copayment maximum (on pharmacy dispensed drugs) will be $4,000 per member/$8,000 for a family of 2 or more members (was $3,650/$7,300).

**KP Gold I $20 Plan**

- Annual prescription drug copayment maximum (on pharmacy dispensed drugs) will be $5,400 per member/$10,800 for a family of 2 or more members (was $4,850/$9,700).
- Annual prescription drug deductible for brand and specialty drugs will be $1,000 per member/$2,000 for a family of 2 or more members (was $700/$1,400).
Kaiser Permanente Group Plan
Benefit and Payment Chart

W.W. GRAINGER, 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 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.

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.
<table>
<thead>
<tr>
<th>Description</th>
<th>Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Copayment Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td>$2,500 per calendar year</td>
</tr>
<tr>
<td>Family Unit (3 or more members)</td>
<td>$7,500 per calendar year</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td>None</td>
</tr>
<tr>
<td>Family Unit</td>
<td>None</td>
</tr>
<tr>
<td><strong>Routine and Preventive</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Health Education and Disease Management</strong></td>
<td></td>
</tr>
<tr>
<td>• Physician Visits</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Tobacco Cessation and Counseling Sessions</td>
<td>None</td>
</tr>
<tr>
<td>• Health education publications</td>
<td>None</td>
</tr>
<tr>
<td>• Healthy Living Classes</td>
<td>Applicable class fees</td>
</tr>
<tr>
<td><strong>Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))</strong></td>
<td>None</td>
</tr>
<tr>
<td>• Office visit for (CDC) Immunizations</td>
<td>None</td>
</tr>
<tr>
<td>• Office visit for Travel Immunization</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Unexpected Mass Population Immunizations</td>
<td>50% of all Applicable Charges</td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
</tr>
<tr>
<td>• Well-Child Care</td>
<td>None</td>
</tr>
<tr>
<td>• Annual Preventive Care (physical exam) Office Visit</td>
<td>None</td>
</tr>
<tr>
<td>• Hearing Exam (for correction)</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Vision Exam (for glasses)</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Preventive Screenings and Care</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Total Health Assessment (<a href="http://www.kp.org">www.kp.org</a>)</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Special Services for Women</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>• Annual Gynecological Exam</td>
<td>None</td>
</tr>
<tr>
<td>• Mammography (screening)</td>
<td>None</td>
</tr>
<tr>
<td>• Pap Smears (cervical cancer screening)</td>
<td>None</td>
</tr>
<tr>
<td><strong>Family Planning Visits</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Infertility Consultation</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>In Vitro Fertilization</strong></td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td></td>
</tr>
<tr>
<td>• Maternity Care—routine prenatal visits</td>
<td>None</td>
</tr>
<tr>
<td>• Maternity Care—delivery</td>
<td>10% of applicable charges</td>
</tr>
<tr>
<td>• Maternity Care—one postpartum visit</td>
<td>None</td>
</tr>
<tr>
<td>Description</td>
<td>Cost Share</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Maternity and Newborn Length of Stay</td>
<td>10% of applicable charges</td>
</tr>
<tr>
<td>Breast Pump</td>
<td>None</td>
</tr>
</tbody>
</table>

Contraceptive Drugs and Devices

See Prescription Drugs

Pregnancy Termination

- Primary Care $20 per visit
- Specialty Care $20 per visit
- Total Care Settings Included in Total Care Services

Voluntary Sterilization (including tubal ligation)

- Medical Office None
- Total Care Settings Included in Total Care Settings

Special Services for Men

Prostate Specific Antigen (screening) $10 per day

Vasectomy

- Primary Care $20 per visit
- Specialty Care $20 per visit
- Total Care Settings Included in Total Care Settings

Online Care

My Health Manager (www.kp.org) None

Office Visits

Office Visits

- Primary Care $20 per visit
- Specialty Care $20 per visit
- Routine pre-surgical and post-surgical None

Urgent Care Visits

- Within Service Area (Primary Care) $20 per visit
- Within Service Area (Specialty Care) $20 per visit
- Outside Service Area 20% of Applicable Charges

Dependent Child Outside of Service Area

- Routine Primary Care $20 per visit
- Basic laboratory and general imaging $10 per visit
- Testing 20% of applicable charges
- Self-administered drug prescriptions 20% of applicable charges

House Calls

- Primary Care $20 per visit
- Specialty Care $20 per visit

Telehealth

$20 per visit;
Cost share will vary depending on service.
<table>
<thead>
<tr>
<th>Description</th>
<th>Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Laboratory, Imaging, and Testing</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory</strong></td>
<td></td>
</tr>
<tr>
<td>• Basic</td>
<td>$10 per day</td>
</tr>
<tr>
<td>• Specialty</td>
<td>$10 per day</td>
</tr>
<tr>
<td><strong>Imaging</strong></td>
<td></td>
</tr>
<tr>
<td>• Basic</td>
<td>$10 per day</td>
</tr>
<tr>
<td>• Specialty</td>
<td>$10 per day</td>
</tr>
<tr>
<td><strong>Testing</strong></td>
<td></td>
</tr>
<tr>
<td>• Allergy Testing</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Skilled-Administered Drugs</td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td>• Diagnostic Testing</td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Surgery and Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Reconstructive Surgery</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Covered Mastectomy</td>
<td>10% of applicable charges</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Total Care Services</strong></td>
<td></td>
</tr>
<tr>
<td><em>You only pay a single Cost Share for covered benefits you receive in the following Total Care Service settings:</em></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>10% of applicable charges</td>
</tr>
<tr>
<td>Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)</td>
<td>10% of applicable charges</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>$100 per visit in area, $100 per visit out of area.</td>
</tr>
<tr>
<td>Observation</td>
<td>10% of applicable charges</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>10% of applicable charges, up to 120 days per year</td>
</tr>
<tr>
<td><strong>Dialysis</strong></td>
<td></td>
</tr>
<tr>
<td>• Dialysis</td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td>• Equipment, Training and Medical Supplies for home Dialysis</td>
<td>None</td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
</tr>
<tr>
<td>Air Ambulance</td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td>Ground Ambulance</td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td><strong>Physical, Occupational, and Speech Therapy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Physical and Occupational Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Home Health Care</td>
<td>None</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Description</td>
<td>Cost Share</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>None</td>
</tr>
<tr>
<td>Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
</tbody>
</table>

### Home Health Care and Hospice Care
- **Home Health Care**: None
- **Hospice Care**: None

### Physician Visits
- **Primary Care**: $20 per visit
- **Specialty Care**: $20 per visit

### Chemotherapy
- **Primary Care**: $20 per visit
- **Specialty Care**: $20 per visit

### 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**: $20 per visit
  - **Total Care Settings**: Included in Total Care Services
- **Chemical Dependency Care**
  - **Medical Office**: $20 per visit
<table>
<thead>
<tr>
<th>Description</th>
<th>Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Autism Care</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td></td>
</tr>
<tr>
<td>Transplant Care for Transplant Recipients</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td>Transplant Care for Transplant Donors (based on health plan approval)</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td>• Related Prescription Drugs</td>
<td>See prescription drugs in this Benefit Summary</td>
</tr>
<tr>
<td><strong>Transplant Evaluations</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Prescription Drug</strong></td>
<td></td>
</tr>
<tr>
<td>Skilled Administered Drugs</td>
<td>20% of applicable charges , Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Self-Administered Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>If your employer has purchased a drug rider, coverage will be as specified in your drug rider following this Benefit Summary</td>
<td></td>
</tr>
<tr>
<td><strong>Chemotherapy Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>• Chemotherapy Infusion or Injections (Skilled Administered Drugs)</td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td>• Chemotherapy–Oral Drugs (Self-Administered Drugs)</td>
<td>20% of applicable charges or as specified in applicable drug rider</td>
</tr>
<tr>
<td><strong>Contraceptive Drugs and Devices</strong></td>
<td>Greater of 50% of applicable charges; or minimum price as determined by Pharmacy Administration</td>
</tr>
<tr>
<td><strong>Diabetic Supplies</strong></td>
<td>Greater of 50% of Applicable Charges; or minimum price as determined by Pharmacy Administration</td>
</tr>
<tr>
<td><strong>Tobacco Cessation Drugs and Products</strong></td>
<td>None (up to 30-day supply)</td>
</tr>
<tr>
<td><strong>Drug Therapy Care</strong></td>
<td></td>
</tr>
<tr>
<td>Growth Hormone Therapy</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Skilled-Administered Drug</td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Home IV/Infusion therapy</strong></td>
<td></td>
</tr>
<tr>
<td>• Therapy and IV drugs</td>
<td>None</td>
</tr>
<tr>
<td>• Self-Administered Injections</td>
<td>See prescription drugs in this Benefit Summary</td>
</tr>
<tr>
<td>Description</td>
<td>Cost Share</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>Inhalation Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Miscellaneous Medical Treatments</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Blood and Blood Products</strong></td>
<td></td>
</tr>
<tr>
<td>• Medical Office</td>
<td>None</td>
</tr>
<tr>
<td>• Rh Immune Globulin</td>
<td>20% of applicable charges</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Dental Procedures for Children</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td></td>
</tr>
<tr>
<td>• Hearing Test</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Appliances</td>
<td>60% of applicable charges for lowest priced</td>
</tr>
<tr>
<td></td>
<td>model, per ear, every 36 months</td>
</tr>
<tr>
<td><strong>Hyperbaric Oxygen Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Materials for Dressings and Casts</strong></td>
<td></td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Cost Share will vary upon place of service</td>
</tr>
<tr>
<td></td>
<td>Included in Total Care Services</td>
</tr>
<tr>
<td><strong>Medical Foods</strong></td>
<td>20% of Applicable Charges</td>
</tr>
<tr>
<td><strong>Medical Social Services</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Orthodontic Care for the Treatment of Orofacial</strong></td>
<td>From birth</td>
</tr>
<tr>
<td>Anomalies (from birth)</td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Pulmonary Rehabilitation</strong></td>
<td></td>
</tr>
<tr>
<td>• Primary Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Specialty Care</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Total Care Settings</td>
<td>Included in Total Care Services</td>
</tr>
</tbody>
</table>
### Additional services

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed Drugs, Self-Administered</td>
<td>4-Tier Prescription drug 3/10/45/200</td>
</tr>
<tr>
<td>Generic Maintenance Drugs: $3 per prescription</td>
<td></td>
</tr>
<tr>
<td>Other Generic Drugs: $10 per prescription</td>
<td></td>
</tr>
<tr>
<td>Brand-Name Drugs: $45 per prescription</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs: $200</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription drug mail-order incentive</strong></td>
<td>Two drug copayments for a 90-consecutive-day supply</td>
</tr>
<tr>
<td>Special Services for Women</td>
<td>Same infertility cost share listed in the Benefit Summary in the front of this Guide</td>
</tr>
<tr>
<td>Artificial insemination (intrauterine insemination)</td>
<td></td>
</tr>
<tr>
<td>Optical services</td>
<td>Not included</td>
</tr>
<tr>
<td>Dental services</td>
<td>Not included</td>
</tr>
<tr>
<td>Complementary Alternative Medicine</td>
<td>Not included</td>
</tr>
<tr>
<td>Fit Rewards (per calendar year)</td>
<td>$200 gym membership or $10 home fitness program</td>
</tr>
</tbody>
</table>

Health Plan believes coverage under this Evidence of Coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. As permitted by the Patient Protection and Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Questions regarding grandfathered health plans may be directed to Member Services.