KAISER PERMANENTE®

KP Added Choice 405
4595 ASSOCIATION OF UNIVERSITIES
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2019 Features of your Kaiser Permanente Added Choice Group Plan

Benefit	In-network Kaiser Permanente Member pays	Out-of-network † Kaiser Permanente Insurance Company Member pays	
Deductible	None	$100/$300	
Out-of-pocket maximum	N/A	$2,000/$6,000	
Annual supplemental charges maximum (individual / family unit of 3 or more members)	$2,000/$6,000	N/A	
	In-network Kaiser Permanente	**Contracted provider**	**Non-contracted provider**
Preventive services			
Well-child office visits (birth through age 5)	No charge	Covered at 100% of MAC*	Covered at 100% of MAC*
Routine Immunizations	No charge	Covered at 100% of MAC*	Covered at 100% of MAC*
One preventive office visit per calendar year (age 6 and older)	No charge	20% of MAC*	20%of MAC*
One gynecological office visit per calendar year (for female members)	No charge	20% of MAC*	20%of MAC*
Outpatient services			
Primary care office visits	$15 per visit	20% of MAC*	20% of MAC*
Specialty care office visits	$15 per visit	20% of MAC*	20% of MAC*
Routine obstetrical (maternity) care			
Prenatal office visits	No charge	100% of MAC*	100% of MAC*
Postnatal office visit	No charge	100% of MAC*	100% of MAC*
Inpatient services			
Hospital room and board, doctors, medical and surgical services, and anesthesia services	$75 per day	20% of MAC*	20% of MAC*
Laboratory, imaging, and testing services			
Inpatient lab, imaging and testing	Included in hospital copay	20% of MAC*	20% of MAC*
Outpatient lab, imaging and testing	10% of applicable charges	20% of MAC*	20% of MAC*
Mental health services			
Outpatient office visits	$15 per visit	20% of MAC*	20% of MAC*
Hospital inpatient care	$75 per day	20% of MAC*	20% of MAC*
Day treatment or partial hospitalization services	$15 per visit	20% of MAC*	20% of MAC*
Non-hospital residential services	$75 per day	20% of MAC*	20% of MAC*

* 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.

This document is to be used for marketing purposes only. It is a summary and does not fully describe your benefit coverage. Please refer to your group detailed benefit summary for more details on your benefit coverage, exclusions, limitations, and plan terms. For additional information please also refer to your employer, to *Our physicians and locations* directory for practitioner and provider availability, and to your *Member handbook*.

Benefit	In-network Kaiser Permanente Member pays	Out-of-network † Kaiser Permanente Insurance Company Member pays	
	In-network Kaiser Permanente	Contracted provider	Non-contracted provider
Chemical dependency services			
Outpatient office visits	$15 per visit	20% of MAC*	20% of MAC*
Hospital inpatient care	$75 per day	20% of MAC*	20% of MAC*
Day treatment or partial hospitalization services	$15 per visit	20% of MAC*	20% of MAC*
Non-hospital residential services	$75 per day	20% of MAC*	20% of MAC*
Emergency services (for initial treatment only)			
Within the Hawaii service area	$75 copay	N/A	N/A
Outside the Hawaii service area	$75 copay	N/A	N/A
Ambulance services	20% of applicable charges	20% of MAC*	20% of MAC*
Diabetes equipment and internal prosthetics, devices and aids			
Diabetes suplies	50% of applicable charges	20% of MAC*	20% of MAC*
Internal prosthetics, devices and aids	Follows applicable benefit category	20% of MAC*	20% of MAC*
External prosthetics, durable medical equipment	20% of applicable charges	20% of MAC*	20% of MAC*
Hearing Aid	60% of applicable charges	Not covered	Not covered
Lowest priced model, per ear, every 36 months			

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	In-network Kaiser Permanente	**Contracted provider**	**Non-contracted provider**
4-Tier Prescription drug 3/10/45/200 Per prescription	Generic maintenance drugs: $3 Other Generic Drugs: $10 Brand-Name Drugs: $45 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 150	$150 allowance for glasses or contact lenses	$50 hardware allowance	$50 hardware allowance
Complementary Alternative Medicine Chiropractic, acupuncture, and massage services (up to 12 visits per calendar year)	(Provided by American Specialty Health Services) $20 per visit		
Fit Rewards per calendar year	$200 gym membership or $10 home fitness program		

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