



KP Added Choice 405  
4595 ASSOCIATION OF UNIVERSITIES  
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## 2020 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	
<b>Deductible</b>	None	\$100/\$300	
<b>Out-of-pocket maximum</b>	N/A	\$2,000/\$6,000	
<b>Annual supplemental charges maximum</b> (individual / family unit of 3 or more members)	\$2,000/\$6,000	N/A	
	In-network Kaiser Permanente	Contracted provider	Non-contracted provider
<b>Preventive services</b> Well-child office visits (birth through age 5) Routine Immunizations One preventive office visit per calendar year (age 6 and older) One gynecological office visit per calendar year (for female members)	No charge No charge No charge No charge	Covered at 100% of MAC* Covered at 100% of MAC* 20% of MAC* 20% of MAC*	Covered at 100% of MAC* Covered at 100% of MAC* 20% of MAC* 20% of MAC*
<b>Outpatient services</b> Primary care office visits Specialty care office visits Routine obstetrical (maternity) care Prenatal office visits Postnatal office visit	\$15 per visit \$15 per visit No charge No charge	20% of MAC* 20% of MAC* Covered at 100% of MAC* Covered at 100% of MAC*	20% of MAC* 20% of MAC* Covered at 100% of MAC* Covered at 100% of MAC*
<b>Inpatient services</b> Hospital room and board, doctors, medical and surgical services, and anesthesia services	\$75 per day	20% of MAC*	20% of MAC*
<b>Laboratory, imaging, and testing services</b> Inpatient lab, imaging and testing Outpatient lab, imaging and testing	Included in hospital copay 10% of applicable charges	20% of MAC* 20% of MAC*	20% of MAC* 20% of MAC*
<b>Mental health services</b> Outpatient office visits Hospital inpatient care Day treatment or partial hospitalization services Non-hospital residential services	\$15 per visit \$75 per day \$15 per visit \$75 per day	20% of MAC* 20% of MAC* 20% of MAC* 20% of MAC*	20% of MAC* 20% of MAC* 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
<b>Chemical dependency services</b> Outpatient office visits Hospital inpatient care Day treatment or partial hospitalization services Non-hospital residential services	\$15 per visit \$75 per day \$15 per visit \$75 per day	20% of MAC* 20% of MAC* 20% of MAC* 20% of MAC*	20% of MAC* 20% of MAC* 20% of MAC* 20% of MAC*
<b>Emergency services (for initial treatment only)</b> Within the Hawaii service area Outside the Hawaii service area	\$75 copay \$75 copay	N/A N/A	N/A N/A
<b>Ambulance services</b>	20% of applicable charges	20% of MAC*	20% of MAC*
<b>Diabetes equipment and internal prosthetics, devices and aids</b> Diabetes supplies Internal prosthetics, devices and aids	50% of applicable charges Follows applicable benefit category	20% of MAC* 20% of MAC*	20% of MAC* 20% of MAC*
<b>External prosthetics, durable medical equipment</b> <b>Hearing Aid</b> Lowest priced model, per ear, every 36 months	20% of applicable charges 60% of applicable charges	20% of MAC* Not covered	20% of MAC* Not covered

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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
<b>4-Tier Prescription drug 3/10/45/200</b> 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
<b>Prescription drug mail-order incentive</b>	Two drug copayments for a 90-consecutive-day supply	N/A	N/A
<b>Optical 150</b>	\$150 allowance for glasses or contact lenses	\$50 hardware allowance	\$50 hardware allowance
<b>Complementary Alternative Medicine Chiropractic, acupuncture, and massage services</b> (up to 12 visits per calendar year)	(Provided by American Specialty Health Services) \$20 per visit		
<b>Fit Rewards</b> per calendar year	\$200 gym membership or \$10 home fitness program		

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