KAISER PERMANENTE® : HMO Group Plan **Coverage for: Individual / Family | Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-800-966-5955 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-966-5955 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,500 Individual/ $7,500 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-966-5955 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	Not Covered	No charge for children through age 17.
	Specialist visit	$15/visit	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: $15/day (basic); Xray: $15/day	Not Covered	Lab: 20% coinsurance (specialty); Inpatient fee included in Hospital stay;
	Imaging (CT/PET scans, MRI's)	20% coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	$10 retail; $20 mail order/ prescription	Not Covered	$3 Maintenance Generic. Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	$35 retail; $70 mail order/ prescription	Not Covered	Up to 30-day retail or 90-day mail order. Subject to formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	$35 retail; $70 mail order/ prescription	Not Covered	Up to 30-day retail or 90-day mail order. Subject to formulary guidelines. Certain drugs may be covered at a different cost share.
	Specialty drugs	$200 retail prescription	Not Covered	Up to 30-day retail. Certain drugs may be covered at a different cost share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	None
	Physician/surgeon fees	10% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	$100/visit	$100/visit	Must notify KP within 48 hours if admitted to a non plan provider.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$15/visit	Not Covered	Non-plan providers covered when temporarily outside the service area: 20% coinsurance
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	None
	Physician/surgeon fee	10% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15/visit	Not Covered	None
	Inpatient services	10% coinsurance	Not Covered	None
If you are pregnant	Office visits	No charge	Not Covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	Professional services are included in the facility services
	Childbirth/delivery facility services	No charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	Physician visit covered at primary care visit copay
	Rehabilitation services	$15/visit (outpatient); 10% coinsurance (inpatient).	Not Covered	None
	Habilitation services	Not covered	Not Covered	None
	Skilled nursing care	10% coinsurance	Not Covered	Limited to 120 days/benefit period
	Durable medical equipment	20% coinsurance; 50% coinsurance for Diabetic Supplies and Equipment	Not Covered	Subject to formulary guidelines.
	Hospice service	No Charge	Not Covered	Includes two 90-day periods, followed by unlimited number of 60-day periods
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam	Not Covered	Limited to 1 exam / year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Chiropractic Care
- Cosmetic Surgery
- Dental care (Adult)
- Habilitation Services
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Travelling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Hearing Aids (Every 3 years)
- Infertility Treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-966-5955 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Hawaii Department of Insurance	1-808-586-2790 or http://cca.hawaii.gov/ins/

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-966-5955 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-966-5955 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-966-5955 (TTY: 711)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-966-5955 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-966-5955 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-966-5955 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-966-5955 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, á'gang 1-800-966-5955 (TTY: 711)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$15**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$15**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$20**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$15**
- **Hospital (facility) coinsurance** **10%**
- **Other (blood work) copayment** **$15**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,100**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$15**
- **Hospital (facility) coinsurance** **10%**
- **Other (x-ray) copayment** **$15**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

The plan would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - ☐ Qualified sign language interpreters
  - ☐ Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide free language services to people whose primary language is not English, such as:
  - ☐ Qualified interpreters
  - ☐ Information written in other languages

If you need these services, call **1-800-966-5955** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Membership Services
Attn: Kaiser Civil Rights Coordinator
711 Kapiolani Blvd
Honolulu, HI 96813
1-800-966-5955

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-966-5955** (TTY: **711**).

Cebuano (Bisaya) ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa **1-800-966-5955** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-966-5955**（TTY：**711**）。

Chuuk (Chukese) MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori **1-800-966-5955** (TTY: **711**).

‘Ōlelo Hawai‘i (Hawaiian) E NĀNĀ MAI: Inā ho‘opuka ‘oe i ka ‘ōlelo Hawai‘i, hiki iā ‘oe ke loa‘a i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

Iloko (Ilocano) PAKDAAR: No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka. Awagan ti **1-800-966-5955** (TTY: **711**).

日本語（Japanese）注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-966-5955**（TTY:**711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-966-5955** (TTY: **711**)번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-966-5955** (TTY: **711**).

Kajin Majōḷ (Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk **1-800-966-5955** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti’go Diné Bizaad, saad bee áká’ánída’áwo’dęę’, t’áá jiik’eh, éí ná hóló, kojį’ hódíílnih **1-800-966-5955** (TTY: **711**).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien lokaia kak sawas ni sohte isais. Koahl nempe **1-800-966-5955** (TTY: **711**).

Faa-Samoa (Samoan) MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoani, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-800-966-5955** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-966-5955** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-966-5955** (TTY: **711**).

Lea Faka-Tonga (Tongan) FAKATOKANGA’I: Kapau ‘oku ke Lea Faka-Tonga, ko e kau tokoni fakatonu lea ‘oku nau fai atu ha tokoni ta’etotongi, pea teke lava ‘o ma’u ia. Telefoni mai **1-800-966-5955** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-966-5955** (TTY: **711**).

Kaiser Permanente Group Plan 320 Benefit and Payment Chart

Kaiser Permanente Multisite Plan (KPMP)

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 may 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, 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.

Description	Cost Share
Annual Copayment Maximum	
Member	$2,500 per calendar year
Family Unit (3 or more members)	$7,500 per calendar year
Annual Deductible	
Member	None
Family Unit	None
Routine and Preventive	
Health Education and Disease Management	
•Medical Office Visits	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Tobacco Cessation and Counseling Sessions	None
•Health education publications	None
•Healthy Living Classes	Applicable class fees
Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))	None
•Office visit for (CDC) Immunizations	None
•Office visit for Travel Immunization	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
Medical Office Visits	
•Well-Child Care	None
•Annual Preventive Care (physical exam)	None
•Hearing Exam (for correction)	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Vision Exam (for glasses)	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
Preventive Screenings and Care	None
Total Health Assessment (www.kp.org)	None
Special Services for Women	
Preventive Care	
•Annual Gynecological Exam	None
•Mammography (screening)	None
•Pap Smears (cervical cancer screening)	None
Family Planning Visits	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
Infertility Consultation	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
In Vitro Fertilization	20% of Applicable Charges
Maternity	
•Maternity Care–routine prenatal visits in Medical Office	None
•Maternity Care–delivery	None

Description	Cost Share
•Maternity Care–postpartum visits in Medical Office	None
•Maternity and Newborn Inpatient Stay	None
•Breast Pump	None
Pregnancy Termination	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
Voluntary Sterilization (including tubal ligation)	
•Medical Office	None
•Total Care Settings	None
Special Services for Men	
Vasectomy	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Settings
Online Care	
My Health Manager (www.kp.org)	None
Medical Office Visits	
Medical Office Visits	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Routine pre-surgical and post-surgical	None
Office visits for children through age 17	
• Primary care	None
• Specialty care	$15 per visit
Urgent Care Visits	
•Within Service Area (Primary Care)	$15 per visit
•Outside Service Area	20% of Applicable Charges
Dependent Child Outside of Service Area	
• Outpatient Care	$20 per visit for the first 10 visits, and 50% of Applicable Charges for additional visits
• Basic laboratory and general imaging	$10 per visit for the first 10 visits (combined total for laboratory, imaging, and testing), and 50% of Applicable Charges for additional visits
• Testing	20% of Applicable Charges for the first 10 visits (combined total for laboratory, imaging, and testing), and 50% of Applicable Charges for additional visits
• Immunizations	None
• Contraceptive drugs and devices	None
• Self-administered drug prescriptions	20% of Applicable Charges for the first 10 prescriptions, and 50% of Applicable Charges for additional prescriptions
House Calls	
•Primary Care	$15 per visit

Description	Cost Share
•Specialty Care	$15 per visit
Telehealth	Cost Share, if applicable, will vary depending on service.
Laboratory, Imaging, and Testing	
Laboratory	
•Basic	$15 per day
•Specialty	20% of Applicable Charges
Imaging	
•Basic	$15 per day
•Specialty	20% of Applicable Charges
Testing	
•Allergy Testing	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Skilled-Administered Drugs	20% of Applicable Charges
•Diagnostic Testing	20% of Applicable Charges
Surgery	
Outpatient Surgery and Procedures	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
Reconstructive Surgery	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Covered Mastectomy	10% of Applicable Charges
•Total Care Settings	Included in Total Care Services
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	10% of Applicable Charges
Outpatient Surgery and Procedures in a Hospital-Based Setting or Ambulatory Surgery Center (ASC)	10% of Applicable Charges
Emergency Services	$100 per visit in area, $100 per visit out of area.
Observation	None
Skilled Nursing Facility	10% of Applicable Charges up to 120 days per Accumulation Period
Dialysis	
•Dialysis	20% of Applicable Charges
•Equipment, Training and Medical Supplies for home Dialysis	None
Radiation Therapy	20% of Applicable Charges
Ambulance	
Air Ambulance	20% of Applicable Charges
Ground Ambulance	20% of Applicable Charges
Physical, Occupational, and Speech Therapy	

Description	Cost Share
Physical and Occupational Therapy	
•Medical Office	$15 per visit
•Home Health Care	None
•Total Care Settings	Included in Total Care Services
Speech Therapy	
•Primary Care	$15 per visit
•Home Health Care	None
•Total Care Settings	Included in Total Care Services
Home Health Care and Hospice Care	
Home Health Care	None
Hospice Care	None
Physician Visits	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
Chemotherapy Services	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
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	$15 per visit
•Total Care Settings	Included in Total Care Services

Description	Cost Share
Chemical Dependency Care	
•Medical Office	$15 per visit
•Total Care Settings	Included in Total Care Services
Autism Care	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
Transplants	
Transplant Care for Transplant Recipients	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
Transplant Care for Transplant Donors (based on health plan approval)	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
•Related Prescription Drugs	See prescription drugs in this *Benefit Summary*
Transplant Evaluations	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
Prescription Drug	
Skilled Administered Drugs	20% of Applicable Charges, (included in Total Care Services)
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
•Chemotherapy–Oral Drugs (Self-Administered Drugs)	20% of Applicable Charges, or as specified in applicable drug rider
Contraceptive Drugs and Devices	50% of Applicable Charges or none
Diabetic Supplies	50% of Applicable Charges
Tobacco Cessation Drugs and Products	None (up to 30-day supply)
Drug Therapy Care	
Growth Hormone Therapy	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Skilled-Administered Drug	20% of Applicable Charges
•Total Care Settings	Included in Total Care Services
Home IV/Infusion therapy	
•Therapy and IV drugs	None
•Self-Administered Injections	See prescription drugs in this *Benefit Summary*
Inhalation Therapy	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services

Description	Cost Share
Miscellaneous Medical Treatments	
Blood and Blood Products	
•Medical Office	None
•Rh Immune Globulin	20% of Applicable Charges
•Total Care Settings	Included in Total Care Services
Dental Procedures for Children	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
Hearing Aids	
•Hearing Test	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Appliances	20% of Applicable Charges
Hyperbaric Oxygen Therapy	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services
Materials for Dressings and Casts	Cost Share will vary upon place of service
•Total Care Settings	Included in Total Care Services
Medical Foods	20% of Applicable Charges
Medical Social Services	None
Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
Rehabilitation Services	
•Primary Care	$15 per visit
•Specialty Care	$15 per visit
•Total Care Settings	Included in Total Care Services

Description	Cost Share
Additional services	
Prescribed Drugs, Self-Administered Generic Maintenance Drugs: $3 per prescription Other Generic Drugs: $10 per prescription Brand-Name Drugs: $35 per prescription Specialty drugs: $200	**4-Tier Prescription drug** **3/10/35/200**
Prescription drug **mail-order incentive**	Two drug copayments for a 90-consecutive-day supply
Special Services for Women Artificial insemination (intrauterine insemination)	Same infertility cost share listed in the *Benefit Summary* in the front of this Guide
Optical services	Not included
Dental services	Not included
Complementary Alternative Medicine	Not included
Fit Rewards (per calendar year)	$200 gym membership or $0 home fitness program