

# Kaiser Permanente Group Plan 320

## Benefit and Payment Chart

10119 CITY AND COUNTY OF SAN FRANCISCO

### 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](http://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
<b>Annual Copayment Maximum</b>	
Member	\$2,500 per calendar year
Family Unit (3 or more members)	\$7,500 per calendar year
<b>Annual Deductible</b>	
Member	None
Family Unit	None
<b>Routine and Preventive</b>	
<b>Health Education and Disease Management</b>	
•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
<b>Immunizations (endorsed by the Centers for Disease Control and Prevention (CDC))</b>	None
•Office visit for (CDC) Immunizations	None
•Office visit for Travel Immunization	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
<b>Medical Office Visits</b>	
•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
<b>Preventive Screenings and Care</b>	None
<b>Total Health Assessment (<a href="http://www.kp.org">www.kp.org</a>)</b>	None
<b>Special Services for Women</b>	
<b>Preventive Care</b>	
•Annual Gynecological Exam	None
•Mammography (screening)	None
•Pap Smears (cervical cancer screening)	None
<b>Family Planning Visits</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
<b>Infertility Consultation</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
<b>In Vitro Fertilization</b>	20% of applicable charges
<b>Maternity</b>	
•Maternity Care—routine prenatal visits in Medical Office	None
•Maternity Care—delivery	None

Description	Cost Share
<ul style="list-style-type: none"> <li>•Maternity Care—one postpartum visit in Medical Office</li> </ul>	None
<ul style="list-style-type: none"> <li>•Maternity and Newborn Inpatient Stay</li> </ul>	None
<ul style="list-style-type: none"> <li>•Breast Pump</li> </ul>	None
<b>Contraceptive Drugs and Devices</b>	See Prescription Drugs
<b>Pregnancy Termination</b>	
<ul style="list-style-type: none"> <li>•Primary Care</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>•Specialty Care</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>•Total Care Settings</li> </ul>	Included in Total Care Services
<b>Voluntary Sterilization (including tubal ligation)</b>	
<ul style="list-style-type: none"> <li>•Medical Office</li> </ul>	None
<ul style="list-style-type: none"> <li>•Total Care Settings</li> </ul>	Included in Total Care Settings
<b>Special Services for Men</b>	
<b>Prostate Specific Antigen (screening)</b>	\$15 per visit
<b>Vasectomy</b>	
<ul style="list-style-type: none"> <li>•Primary Care</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>•Specialty Care</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>•Total Care Settings</li> </ul>	Included in Total Care Settings
<b>Online Care</b>	
<b>My Health Manager (www.kp.org)</b>	None
<b>Medical Office Visits</b>	
<b>Medical Office Visits</b>	
<ul style="list-style-type: none"> <li>•Primary Care</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>•Specialty Care</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>•Routine pre-surgical and post-surgical</li> </ul>	None
<b>Office visits for children through age 17</b>	
<ul style="list-style-type: none"> <li>• Primary care</li> </ul>	None
<ul style="list-style-type: none"> <li>• Specialty care</li> </ul>	\$15 per visit
<b>Urgent Care Visits</b>	
<ul style="list-style-type: none"> <li>•Within Service Area (Primary Care)</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>•Outside Service Area</li> </ul>	20% of Applicable Charges
<b>Dependent Child Outside of Service Area</b>	
<ul style="list-style-type: none"> <li>•Routine Primary Care</li> </ul>	\$20 per visit
<ul style="list-style-type: none"> <li>•Basic laboratory and general imaging</li> </ul>	\$10 per visit
<ul style="list-style-type: none"> <li>•Testing</li> </ul>	20% of applicable charges
<ul style="list-style-type: none"> <li>• Immunizations</li> </ul>	None
<ul style="list-style-type: none"> <li>• Contraceptive drugs and devices</li> </ul>	None
<ul style="list-style-type: none"> <li>•Self-administered drug prescriptions</li> </ul>	20% of applicable charges
<b>House Calls</b>	
<ul style="list-style-type: none"> <li>•Primary Care</li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>•Specialty Care</li> </ul>	\$15 per visit
<b>Telehealth</b>	Cost Share, if applicable, will vary depending on service.

Description	Cost Share
<b>Laboratory, Imaging, and Testing</b>	
<b>Laboratory</b>	
•Basic	\$15 per day
•Specialty	20% of applicable charges
<b>Imaging</b>	
•Basic	\$15 per day
•Specialty	20% of applicable charges
<b>Testing</b>	
•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
<b>Surgery</b>	
<b>Outpatient Surgery and Procedures</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
•Total Care Settings	Included in Total Care Services
<b>Reconstructive Surgery</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
•Covered Mastectomy	10% of applicable charges
•Total Care Settings	Included in Total Care Services
<b>Total Care Services</b>	
<i>You may only pay a single Cost Share for covered benefits you receive in the following Total Care Service settings:</i>	
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 calendar year
<b>Dialysis</b>	
•Dialysis	20% of applicable charges
•Equipment, Training and Medical Supplies for home Dialysis	None
<b>Radiation Therapy</b>	20% of applicable charges
<b>Ambulance</b>	
<b>Air Ambulance</b>	20% of applicable charges
<b>Ground Ambulance</b>	20% of applicable charges
<b>Physical, Occupational, and Speech Therapy</b>	
<b>Physical and Occupational Therapy</b>	
•Medical Office	\$15 per visit
•Home Health Care	None

Description	Cost Share
•Total Care Settings	Included in Total Care Services
<b>Speech Therapy</b>	
•Primary Care	\$15 per visit
•Home Health Care	None
•Total Care Settings	Included in Total Care Services
<b>Home Health Care and Hospice Care</b>	
<b>Home Health Care</b>	None
<b>Hospice Care</b>	None
<b>Physician Visits</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
<b>Chemotherapy</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
•Total Care Settings	Included in Total Care Services
<b>Internal, External Prosthetics Devices and Braces</b>	
<b>Implanted Internal Prosthetics, Devices and Aids</b>	
•Medical Office	None
•Total Care Settings	Included in Total Care Services
<b>External Prosthetics Devices</b>	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
<b>Braces</b>	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
<b>Durable Medical equipment</b>	
<b>Durable Medical equipment</b>	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
<b>Oxygen (for use with DME)</b>	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
<b>Repair or Replacement</b>	
•Outpatient	20% of applicable charges
•Total Care Settings	Included in Total Care Services
<b>Diabetes Equipment</b>	50% of Applicable Charges
<b>Home Phototherapy equipment</b>	None
<b>Behavioral Health–Mental Health and Substance Abuse</b>	
<b>Mental Health Care</b>	
•Medical Office	\$15 per visit
•Total Care Settings	Included in Total Care Services
<b>Chemical Dependency Care</b>	
•Medical Office	\$15 per visit
•Total Care Settings	Included in Total Care Services

Description	Cost Share
<b>Autism Care</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
<b>Transplants</b>	
<b>Transplant Care for Transplant Recipients</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
•Total Care Settings	Included in Total Care Services
<b>Transplant Care for Transplant Donors (based on health plan approval)</b>	
•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 <i>Benefit Summary</i>
<b>Transplant Evaluations</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
<b>Prescription Drug</b>	
<b>Skilled Administered Drugs</b>	20% of applicable charges, (included in Total Care Services)
<b>Self-Administered Drugs</b>	<i>If your employer has purchased a drug rider, coverage will be as specified in your drug rider following this Benefit Summary</i>
<b>Chemotherapy Drugs</b>	
•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
<b>Contraceptive Drugs and Devices</b>	50% of applicable charges
<b>Diabetic Supplies</b>	50% of Applicable Charges
<b>Tobacco Cessation Drugs and Products</b>	None (up to 30-day supply)
<b>Drug Therapy Care</b>	
<b>Growth Hormone Therapy</b>	
•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
<b>Home IV/Infusion therapy</b>	
•Therapy and IV drugs	None
•Self-Administered Injections	See prescription drugs in this <i>Benefit Summary</i>
<b>Inhalation Therapy</b>	
•Primary Care	\$15 per visit
•Specialty Care	\$15 per visit
•Total Care Settings	Included in Total Care Services
<b>Miscellaneous Medical Treatments</b>	
<b>Blood and Blood Products</b>	
•Medical Office	None

Description	Cost Share
<ul style="list-style-type: none"> <li>●Rh Immune Globulin</li> <li>●Total Care Settings</li> </ul>	20% of applicable charges Included in Total Care Services
<b>Dental Procedures for Children</b>	
<ul style="list-style-type: none"> <li>●Primary Care</li> <li>●Specialty Care</li> <li>●Total Care Settings</li> </ul>	\$15 per visit \$15 per visit Included in Total Care Services
<b>Hearing Aids</b>	
<ul style="list-style-type: none"> <li>●Hearing Test               <ul style="list-style-type: none"> <li>●Primary Care</li> <li>●Specialty Care</li> </ul> </li> <li>●Appliances</li> </ul>	\$15 per visit \$15 per visit 60% of applicable charges for lowest priced model, per ear, every 36 months
<b>Hyperbaric Oxygen Therapy</b>	
<ul style="list-style-type: none"> <li>●Primary Care</li> <li>●Specialty Care</li> <li>●Total Care Settings</li> </ul>	\$15 per visit \$15 per visit Included in Total Care Services
<b>Materials for Dressings and Casts</b>	Cost Share will vary upon place of service
<ul style="list-style-type: none"> <li>●Total Care Settings</li> </ul>	Included in Total Care Services
<b>Medical Foods</b>	20% of Applicable Charges
<b>Medical Social Services</b>	None
<b>Orthodontic Care for the Treatment of Orofacial Anomalies (from birth)</b>	
<ul style="list-style-type: none"> <li>●Primary Care</li> <li>●Specialty Care</li> </ul>	\$15 per visit \$15 per visit
<b>Pulmonary Rehabilitation</b>	
<ul style="list-style-type: none"> <li>●Primary Care</li> <li>●Specialty Care</li> <li>●Total Care Settings</li> </ul>	\$15 per visit \$15 per visit Included in Total Care Services



Description	Cost Share
<b>Additional services</b>	
<b>Prescribed Drugs, Self-Administered</b>	<b>4-Tier Prescription drug 3/15/50/200</b>
Generic Maintenance Drugs: \$3 per prescription	
Other Generic Drugs: \$15 per prescription	
Brand-Name Drugs: \$50 per prescription	
Specialty drugs: \$200	
<b>Prescription drug mail-order incentive</b>	Two drug copayments for a 90-consecutive-day supply
<b>Special Services for Women</b>	
Artificial insemination (intrauterine insemination)	Same infertility cost share listed in the <i>Benefit Summary</i> in the front of this Guide
<b>Optical services</b>	Not included
<b>Dental services</b>	Not included
<b>Complementary Alternative Medicine</b>	
<b>Chiropractic, acupuncture, and massage therapy services (up to 12 visits per calendar year)</b>	\$20 per visit
<b>Fit Rewards (per calendar year)</b>	\$200 gym membership or \$10 home fitness program