KAISER PERMANENTE®

KPMP Multisite Plan

2014 Features of your Kaiser Permanente Group Plan

Benefit	Member pays
Calendar year deductible (individual / family unit of 3 or more members)	None
Maximum benefit while insured	Unlimited
Supplemental charges maximum (individual / family unit of 3 or more members)	$2500 / $7,500
Preventive services	
Well-child office visits (at birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months)	No charge
Routine Immunizations	No charge
One Preventive care office visit per calendar year (for members 2 years of age and over)	No charge
One gynecological office visit per calendar year for female members	No charge
Outpatient services	
Office visits	$15 per visit
Routine obstetrical care	No charge upon confirmation of pregnancy
Outpatient surgery and procedures	$15 per visit
FDA-approved contraceptive drugs and devices (to prevent unwanted pregnancy)) on Health Plan formulary as required by federal Patient Protection and Affordable Care Act (PPACA)	No charge
Outpatient prescription drugs	Covered
Inpatient services	
Hospital inpatient care includes services such as: • Room and board • General nursing care and special duty nursing • Physicians' services • Surgical procedures • Respiratory therapy and radiation therapy • Anesthesia • Medical supplies • Use of operating and recovery rooms • Intensive care room	$75 per day
Laboratory, imaging, and testing services	
Outpatient laboratory services, imaging services, and testing services / X-ray and laboratory exams	10% of applicable charges
Inpatient laboratory services, imaging services, and testing services / X-ray and laboratory exams	No charge
Outpatient dialysis	
Outpatient dialysis procedures	10% of applicable charges
Skilled nursing care	
Skilled nursing care (up to 100 days per benefit period)	No charge
Mental health services	
Outpatient office visits	$15 per visit
Hospital inpatient care	$75 per day
Chemical dependent services / Substance abuse	
Outpatient office visits	$15 per visit

This is only a summary. This document is meant to be reviewed in conjunction with the attached, detailed benefit summary. It does not fully describe your benefit coverage. For complete details on your benefit coverage, including exclusions, limitations, and plan terms, or for information, please refer to the attached, detailed benefit summary, to your employer, to Our Physicians and Locations directory for practitioner and provider availability, and to your Member Handbook. This document is meant to be reviewed in conjunction with the attached, detailed benefit summary.

Benefit	Member pays
Hospital inpatient care	$75 per day
Non-hospital residential services	$75 per day
Emergency services (for initial treatment only)	
Within the Hawaii service area	$75 per visit
Outside the Hawaii service area	20% of applicable charges
Ambulance services	
Ambulance services	20% of applicable charges
Prescription drug coverage	
Prescription drugs – drug 15	$15 per prescription
Prescription drug mail-order incentive	Two drug copayments for a 90-consecutive-day supply
Diabetic supplies	
Blood glucose test strips, lancets, syringes and needles.	50% of applicable charges
Diabetes equipment	
Blood glucose monitor and control solution	50% of applicable charges
Corrective aids and appliances	
DME and External Prosthetics	20% of applicable charges
Internal prosthetic devices and aids	No charge
Hearing Aid Allowance	$500 per calendar year for up to 2 hearing aid(s)
All care and services must be coordinated by a Kaiser Permanente physician	

(1) One well-woman office visit or office visit for physical exam per calendar year. Preventive screenings covered at no charge include anemia and lead screening for children, colorectal cancer screening, chlamydia detection, fecal occult blood test, lipid profile, newborn metabolic screening, cervical cancer screening, screening mammography, and osteoporosis screening.
(2) At birth, ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months.
(3) Up to a 30-consecutive-day supply or an amount determined by the Health Plan formulary. Excludes contraceptive drugs and devices.
(4) Applies to refills for most maintenance drugs. The mail-order program does not apply to certain drugs and mailing is limited to addresses inside the Hawaii Service Area.
(5) Eye examinations for contact lenses are excluded, but members will receive a $70 professional fee credit for required fitting services (to apply towards the contact lenses examination) if contact lenses are purchased at a Kaiser Permanente facility.