IDENTIFYING NAME OF PLAN: Kaiser Permanente Group Plan

Form HC-7(a-2)
(Rev. 01/12)

"SERVICE" TYPE PLANS

BENEFITS	KPGP MEMBER PAYS	EXPLAIN ANY VARIATION FROM KPGP
OFFICE VISITS	$20.00 per visit	
OUTPATIENT SURGERY AND PROCEDURES	$20.00 per visit (medical office) 10% of applicable charges (ambulatory surgery center or hospital-based setting)	
HOSPITALIZATION 365 days per year	10% of applicable charges	
PREVENTIVE CARE OFFICE VISITS Well child office visits, one preventive care office visit per calendar year (for members over 2 years of age), and one gynecological office visit per calendar year for female members	No charge	
SKILLED NURSING CARE Up to 60 days of skilled nursing care per Benefit Period	10% of applicable charges	
OBSTETRICAL (MATERNITY) CARE Routine: Prenatal, delivery, and postpartum visit	No charge for routine prenatal visits and one postpartum visit 10% of applicable charges for delivery (hospital stay)	
INTERRUPTED PREGNANCY Elective abortion	$20.00 per visit (medical office) 10% of applicable charges (ambulatory surgery center or hospital-based setting) Limited to 2 per lifetime	

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Medically indicated abortion	$20.00 per visit (medical office) 10% of applicable charges (ambulatory surgery center or hospital-based setting) No limit on medically necessary abortions	
IN VITRO FERTILIZATION	20% of applicable charges. One-time only under Kaiser Permanente	
LABORATORY		
Inpatient	Included in the hospitalization copay	
Outpatient	$10.00 per day for basic laboratory services and 20% of applicable charges for specialized laboratory services (e.g. tissue samples, cell studies, chromosome studies, and testing for genetic disease)	
IMAGING		
Inpatient	Included in the hospitalization copay	
Outpatient	$10.00 per day for general radiology and diagnostic mammogram and 20% of applicable charges for all other imaging services (e.g. CT, interventional radiology, MRI, nuclear medicine, and ultrasound)	
TESTING		
Inpatient	Included in the hospitalization copay	
Outpatient	20% of applicable charges	
RADIATION THERAPY		
Inpatient	Included in the hospitalization copay	
Outpatient	20% of applicable charges	

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PHYSICAL, OCCUPATIONAL, SPEECH THERAPY	Limited by significant, measurable improvement, KP clinical guidelines apply	
Inpatient	Included in the hospitalization copay	
Outpatient	$20.00 per visit	
EMERGENCY COVERAGE		
Within Hawaii service area	$100 per visit, plus other applicable plan charges	
Outside Hawaii service area	20% of applicable charges, plus other applicable plan charges	
EMERGENCY AMBULANCE -- AIR & GROUND	20% of applicable charges	
HOME HEALTH CARE	No charge, except $20.00 per visit, for Physician house call	
HOSPICE SERVICES		
(Two 90-day periods, followed by an unlimited number of 60-day periods. The member must be certified by a Physician as terminally ill at the beginning of each period.)	No charge	
MENTAL HEALTH SERVICES		
Inpatient	10% of applicable charges	
Outpatient	$20.00 per visit	
Specialized facility services	$20.00 per visit (day treatment or partial hospitalization)	
	10% of applicable charges (non-hospital residential services)	

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CHEMICAL DEPENDENCY		
Inpatient	10% of applicable charges	
Outpatient	$20.00 per visit	
Specialized facility services	$20.00 per visit (day treatment or partial hospitalization)	
	10% of applicable charges (non-hospital residential services)	
OUT-OF-POCKET LIMITS		
Individual	$2,500 per calendar year	
Family (3 or more individuals)	$7,500 per calendar year	
EXCLUSIONS		
No benefits will be paid in connection with: alternative medical services (e.g. – acupuncture, chiropractic etc…), artificial aids (e.g. - eyeglasses, contact lens, hearing aids etc…), cardiac rehabilitation, corrective appliances (e.g. - orthotics, braces, external prosthetics, splints etc…), cosmetic services, dental care services, services and related paperwork required by an outside agency/body, take home drugs, non-FDA approved drugs and devices, custodial and intermediate level nursing facility services, durable medical equipment, employer or government responsibility, experimental or investigational services, homemaker services, radial keratotomy or similar procedures, long term or maintenance		

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therapies (physical, occupational and speech), take home supplies, travel immunizations, routine foot care, sexual dysfunction, transportation (except for medically necessary ambulance services), lodging, living expenses, gender reassignment, reversal of voluntary infertility, services and supplies not medically necessary.		