

## Summary of Services and Cost Shares

This summary does not describe benefits. For the description of a benefit, including any limitations or exclusions, please refer to the identical heading in the “Benefits” section (also refer to the “Exclusions, Limitations and Reductions” section, which applies to all benefits). **Note:** Additional benefits may also be covered under Riders attached to this EOC, and which follow this Summary of Services and Cost Shares.

### DEPENDENT AGE LIMIT

Eligible Dependent children are covered from birth to age 26.

### MEMBER COST-SHARE

Your Cost Share is the amount of the Allowable Charge for a covered Service that you must pay through Copayments. The Cost Share, if any, is listed for each Service in this “Summary of Services and Cost Shares.”

You are responsible for payment of all Cost Shares at the time you receive a Service. Failure to pay your Cost Shares may result in termination of your Membership (refer to Section 6, Termination for Nonpayment).

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### Missed Appointment Fee

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The amount you may be required to pay if you fail to keep a scheduled appointment and you do not notify us at least one day prior to the appointment.	\$25 per missed appointment
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### Copayments

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Covered Service	You Pay
<b>Outpatient Care</b>	
Office visits (for other than preventive health care Services)	
Primary care office visits	\$15 per visit (Waived for children under age 5)
Specialty care office visits	\$15 per visit
Outpatient surgery	No charge
Diagnostic testing (not preventive screening) as described under Outpatient Care in Section 3	No charge
Anesthesia	No charge
Chemotherapy and radiation therapy	No charge
Respiratory therapy	No charge
<b>Hospital Inpatient Care</b>	
All charges incurred during a covered stay as an inpatient in a hospital	No charge
<b>Accidental Dental Injury Services</b>	Applicable Cost Shares will apply, based on type and place of Service
<b>Allergy Services</b>	
Evaluations and treatment	\$15 per visit
Injection visits and serum	\$15 per visit

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<b>Copayments</b>	
<b>Covered Service</b>	<b>You Pay</b>
<b>Ambulance Services</b>	
By a licensed ambulance Service, per encounter	No charge
Non-emergent transportation Services (ordered by a Plan Provider)	No charge
<b>Anesthesia for Dental Services</b>	
Anesthesia and associated hospital or ambulatory Services for certain individuals only.	No charge
<b>Blood, Blood Products, and their Administration</b>	
<b>Chemical Dependency and Mental Health Services</b>	
Treatment of mental illness, emotional disorders, drug and alcohol abuse described in the “Benefits” section	No charge
Inpatient psychiatric and substance abuse care, including detoxification	No charge
Residential treatment center	No charge
Partial hospitalization	No charge
Outpatient psychiatric and substance abuse care	
• Individual therapy	\$15 per visit
• Group therapy	\$7 per visit
Psychiatric Residential Crisis Services	No charge
Methadone treatment	No charge
All other outpatient treatment	No charge
Medication management	\$15 per visit
<b>Chiropractic and Acupuncture Services</b>	\$15 per visit
<b>Cleft Lip, Cleft Palate, or Both</b>	
<b>Clinical Trials</b>	
<b>Diabetic Equipment, Supplies, and Self-Management Training</b>	
Diabetic equipment and supplies	No charge
Self-management training	
• Training during office visit	\$15 per visit
• Other training	No charge
<b>Dialysis</b>	
Inpatient care	No charge

<b>Copayments</b>	
<b>Covered Service</b>	<b>You Pay</b>
Outpatient Care	No charge
<b>Drugs, Supplies, and Supplements</b> Administered by or under the supervision of a Plan Provider	No charge
<b>Durable Medical Equipment</b>	No charge
<b>Emergency Room Services</b>	No charge if admitted as an inpatient
Observation for less than 24 hours	\$150 per visit (\$75 for facility and \$75 for Physician)
Observation for 24 hours or more	No charge
<b>Note:</b> If criteria are not met for a medical emergency, Plan coverage is 50% of Allowable Charge, plus the two \$75 copayments	
<b>Family Planning</b>	
Office visits (other than WPS)	\$15 per visit
Vasectomy, Voluntary termination of pregnancy	Applicable Cost Share will apply, based on place of Service
Women’s Preventive Services (WPS): All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	No charge
<b>Habilitative Services - Outpatient</b>	\$15 per visit
<b>Hearing Services</b>	
Hearing tests (newborn hearing screening tests are covered under preventive health care Services at no charge)	\$15 per visit
Hearing aids	
• Hearing aid tests	No charge
• Hearing aids (Limited to a single hearing device per hearing impaired ear, every 36 months)	No charge
<b>Home Health Care</b>	No charge
Limited to a maximum benefit of 120 days per Member per contract year. The visit maximum does not apply to home visits following mastectomy or testicle removal; or postpartum home visits.	
<b>Hospice Care</b>	No charge
<b>Infertility Services</b> (Inpatient treatment, outpatient surgery, or outpatient visits) Note: Coverage for in vitro fertilization is limited to a maximum of three attempts per live birth and artificial	Applicable Cost Share will apply, based on type and place of Service

<b>Copayments</b>	
<b>Covered Service</b>	<b>You Pay</b>
insemination is limited to six attempts.	
<b>Maternity Services</b>	
Prenatal and postpartum visits (after confirmation of pregnancy), including diagnostic tests	No charge
Delivery	No charge
Postpartum home visits (as described in Section 3)	No charge
<b>Medical Foods (including Amino Acid-based Elemental Formula)</b>	No charge
<b>Morbid Obesity Services</b>	No charge
<b>Nutritional Counseling/Medical Nutrition Therapy</b>	No charge
<b>Oral Surgery</b>	No charge
<b>Private Duty Nursing - Outpatient</b>	No charge
<b>Prescription Drugs</b>	Not covered
Benefits are not available through Health Plan for Pharmacy-dispensed Prescription Drugs. Benefits available through Health Plan for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Plan Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Plan Provider, and dispensed in the office of a Plan Provider.	
<b>Preventive Health Care Services</b>	No charge
<b>Prosthetic and Orthotic Devices</b>	No charge
See Section 3 for description of benefits	
<b>Reconstructive Surgery</b>	No charge
<b>Skilled Nursing Facility Care</b> (Limited to a maximum benefit of 180 days per contract year)	No charge
<b>Telemedicine Services</b>	No charge
<b>Therapy and Rehabilitation Services - Outpatient</b> (Physical/Occupational Therapy services must be pre-certified after the 6 <sup>th</sup> visit, based on medical necessity; Limited to 50 days per contract year combined for Physical, Occupational and Speech Therapy)	\$15 per visit
<b>Transgender Surgery</b>	Applicable Cost Share will apply, based on place of Service

**Copayments**

Covered Service	You Pay
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<b>Transplants</b>	No charge
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**Travel Benefit**

Outpatient follow-up and/or continuing medical and mental health and substance abuse care outside of your Home Service Area	No charge
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\*Note: You must be temporarily outside of your home Service Area by more than 100 miles and outside of any other Kaiser Permanente Service area. Health plan limits its payment for this travel benefit to \$1,200 each calendar year.

<b>Urgent Care</b>	\$15 per visit
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**Vision Exam Services (adult age 19 or older)**

Eye exams

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| <ul style="list-style-type: none"> <li>• Routine (one per contract year)</li> <li>• Non-routine</li> </ul> | No charge<br>\$15 per visit |
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Eyewear –Lenses (per contract year)	Member allowance: Single vision \$52.00, Bifocal (single) \$82.00, Bifocal (double) \$88.20, Trifocal \$101.00, Lenticular \$181.00
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Eyewear -Frames (per contract year)	Member allowance: \$45.00
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Contact lenses (per contract year)	Member allowance: Per pair, in lieu of frames and lenses: Medically Necessary - \$285.00, Cosmetic - \$97.00
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Note: Member pays any cost above the allowance.

**Vision Services (for children under age 19)**

Eye exams

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| <ul style="list-style-type: none"> <li>• Routine (one per contract year)</li> <li>• Non-routine</li> </ul> | No charge<br>\$15 per visit |
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Note: Pediatric vision hardware chosen from a select group is covered at no charge.

Eyeglass lenses and frames	No charge
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Contact lenses	No charge
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Low vision aids	No charge
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Note: Contact lenses, including medically necessary contact lenses, are covered in lieu of eyeglasses.

**Additional Vision Services (for children under age 19)**

For pediatric vision hardware not included in select group, the member pays any cost above the State provided allowed

**Copayments**

Covered Service	You Pay
amount.	
<ul style="list-style-type: none"> <li>• Frames <span style="float: right;">Allowed Amount \$70</span></li> <li>• Lenses                             <ul style="list-style-type: none"> <li>- Basic Single Vision <span style="float: right;">Allowed Amount \$40</span></li> <li>- Basic Bifocals <span style="float: right;">Allowed Amount \$60</span></li> <li>- Basic Trifocals <span style="float: right;">Allowed Amount \$80</span></li> <li>- Basic Lenticular <span style="float: right;">Allowed Amount \$100</span></li> </ul> </li> <li>• Contact lenses (in lieu of frames and lenses)                             <ul style="list-style-type: none"> <li>- Contact lenses <span style="float: right;">Allowed Amount \$105</span></li> <li>- Medically Necessary Contacts <span style="float: right;">Allowed Amount \$225</span></li> </ul> </li> </ul>	

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**X-ray, Laboratory and Special Procedures**

Diagnostic imaging and laboratory tests

Inpatient Services	No charge
Outpatient Services	No charge

Specialty Imaging (including CT, MRI, PET Scans, Nuclear Medicine); Interventional Radiology and Special Procedures

Inpatient Services	No charge
Outpatient Services	No charge

Sleep lab and sleep studies No charge

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**Copayment Maximum**

The Copayment Maximum is the limit to the total amount of Copayments you must pay in a contract year for the Basic Health Services (listed below) covered under this EOC. Once you have met the Copayment Maximum, you will not be required to pay any additional Copayments for these Basic Health Services. After two or more Members of a Family Unit combined have met the Family Copayment Maximum, the Copayment Maximum will be met for all Members of the Family Unit for the rest of the contract year.

**Basic Health Services.** Except as excluded below, the following Services are considered Basic Health Services that apply toward the Copayment Maximum:

- Inpatient and outpatient physician Services
- Inpatient hospital Services
- Outpatient medical Services
- Preventive health care Services
- Emergency Services
- X-ray, laboratory, and special procedures
- Inpatient and outpatient chemical dependency and mental health Services

**Copayment Maximum Exclusions.** The following Services, if covered, are *not* considered Basic Health Services and *do not* apply toward your Copayment Maximum. Your Cost Share for these Services will continue to apply

**Copayments**

Covered Service	You Pay
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even after you have met your Copayment Maximum:

- Adult vision Services

**Keep Your Receipts.** When you pay a Cost Share, we will give you a receipt. Keep your receipts. If you have met your Copayment Maximum, and we have not received and processed all of your claims, you may use your receipts to prove that you have met your Copayment Maximum. You can also obtain a statement of the amounts that have been applied toward your Copayment Maximum from our Member Services Department.

**Notice of Copayment Maximum.** We will also keep accurate records of your Copayment expenses and will notify you when you have reached the maximum. We will send you written notice no later than 30 days after we have received and processed your claims that the Copayment Maximum is reached. If you have exceeded your Copayment Maximum, we will promptly refund to you any Copayments charged after the maximum was reached.

<b>Annual Copayment Maximum</b>	
Combined total of allowable Copayments for Basic Health Services	<p><b>Individual Copayment Maximum</b> \$1,500 per individual per contract year</p> <p><b>Family Copayment Maximum</b> \$3,000 per Family Unit per contract year</p>