Diamond Resorts Corporation
• kp.org

2017 Features of your Kaiser Permanente Group Plan

Benefit	Member Pays
Deductible	None
Annual supplemental charges maximum per calendar year	$2,500 / $7,500
Preventive service	
Well-child office visits	No charge
Routine immunizations	No charge
One preventive care office visit per calendar year (age 2 and older)	No charge
One gynecological office visit per calendar year (for female members)	No charge
Outpatient services	
Primary care office visits	$20 per visit
Specialty care office visits	$20 per visit
Routine obstetrical (maternity) care	No charge
Inpatient services	
Hospital room and board, doctors, medical and surgical services, and anesthesia services	10% of applicable charges
Laboratory, imaging, and testing services	
Inpatient lab, imaging, and testing	Included in hospital inpatient copay
Outpatient imaging services and testing services	$10 per day for basic labs and imaging, 20% of applicable charges for complex labs and imaging; 20% of applicable charges for testing
Mental health services	
Outpatient office visits	$20 per visit
Hospital inpatient care	10% of applicable charges
Day treatment or partial hospitalization services	$20 per visit
Non-hospital residential services	10% of applicable charges
Chemical dependency services	
Outpatient office visits	$20 per visit
Hospital inpatient care	10% of applicable charges
Day treatment or partial hospitalization services	$20 per visit
Non-hospital residential services	10% of applicable charges
Emergency services (for initial treatment only)	
Within the Hawaii service area	$100 per visit
Outside the Hawaii service area	$100 per visit
Ambulance services	20% of applicable charges
Diabetes supplies and internal prosthetics, devices and aids	
Diabetes supplies	50% of applicable charges
Internal prosthetics, devices, and aids	No charge
External prosthesis / durable medical equipment	20% of applicable charges
Hearing aid	60% of applicable charges for lowest priced hearing aid, per ear, every 36 months

All care and services must be coordinated by a Kaiser Permanente physician.

This document is to be used for marketing purposes only. It is a summary and does not fully describe your benefit coverage. Please refer to your group detailed benefit summary for more details on your benefit coverage, exclusions, limitations, and plan terms. For additional information please also refer to your employer, to *Our physicians and locations* directory for practitioner and provider availability, and to your *Member handbook*.

Benefit	Member Pays
Additional services	
4-Tier prescription drug 3/10/45/200	$3 Generic Maintenance Drugs: $10 Other Generic Drugs: $45 Brand-Name Drugs: $200 Specialty Drugs:
Prescription drug-mail order incentive	Two drug copayments for a 90-consecutive-day supply
Chiropractic, acupuncture, and massage therapy services	
Up to 12 visits per calendar year	$20 per visit
Active&Fit	$200 per contract year gym membership or $10 per calendar year home fitness program

This document is to be used for marketing purposes only. It is a summary and does not fully describe your benefit coverage. Please refer to your group detailed benefit summary for more details on your benefit coverage, exclusions, limitations, and plan terms. For additional information please also refer to your employer, to *Our physicians and locations* directory for practitioner and provider availability, and to your *Member handbook*.