

# HEWT Kaiser Permanente OPTIONS MEDICAL

## PLAN EFFECTIVE 1/1/2019

BENEFITS	INSIDE NETWORK	OUT-OF-NETWORK
<b>Plan Deductible—Per Calendar Year (PCY)</b>	Individual deductible: \$150 Family deductible: \$300	Individual deductible: \$250 Family deductible: \$500
<b>Individual Deductible Carryover</b>	4th quarter carryover applies.	4th quarter carryover applies.
<b>Plan Co-insurance</b>	Plan pays 80%, you pay 20%.	Plan pays 70%, you pay 30% of the Allowed Amount.
<b>Out-Of-Pocket Limit (PCY)</b>	Individual out-of-pocket limit: \$1,150 Family out-of-pocket limit: \$2,300	Individual out-of-pocket limit: \$2,875 Family out-of-pocket limit: \$5,750
<b>Pre-existing Condition (PEC) Waiting Period</b>	No waiting period for a PEC.	No waiting period for a PEC.
<b>Lifetime Maximum</b>	No lifetime maximum.	No lifetime maximum.
<b>Outpatient Services (Office Visits)</b>	Deductible and co-insurance apply.	Deductible and co-insurance apply.
<b>Hospital Services</b>	<b>Inpatient Services:</b> Deductible and co-insurance apply. <b>Outpatient Surgery:</b> Deductible and co-insurance apply.	<b>Inpatient Services:</b> Deductible and co-insurance apply. <b>Outpatient Surgery:</b> Deductible and co-insurance apply.
<b>Prescription Drugs</b> (Some Injectable Drugs may be Covered under Outpatient Services) See Summary of	<b>Retail: (for a 30-day supply)</b> Generic preferred: \$20 Brand name preferred: \$40 Non-preferred: \$60	<b>Retail: (for a 30-day supply)</b> Generic preferred: \$25 Brand name preferred: \$45 Non-preferred: \$65
<b>Prescription Mail Order</b>	2x prescription cost share per 90 day supply.	Not covered.
<b>Acupuncture</b>	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan. Deductible and co-insurance apply.	Deductible and co-insurance apply.
<b>Ambulance Services</b>	Plan pays 80%, you pay 20%. Not subject to deductible.	Same as in-network.
<b>Chemical Dependency</b>	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.
<b>Devices, Equipment and Supplies</b> Durable medical equipment, Orthopedic appliances, Post-mastectomy bras limited to two (2) every six (6) months, Ostomy supplies, Prosthetic devices	Plan pays 80%, you pay 20%. Not subject to deductible.	Benefits and limits shared with in-network, deductible applies.
<b>Diabetic Supplies</b>	Insulin, needles, syringes lancets, and test strips—see Prescription drugs. External insulin pumps, blood glucose monitors and supplies—see Devices, Equipment and Supplies. Blood glucose monitoring reagents and urine testing reagents are covered in full.	Insulin, needles, syringes lancets, and test strips—see Prescription drugs. External insulin pumps, blood glucose monitors and supplies—see Devices, Equipment and Supplies. Blood glucose monitoring reagents and urine testing reagents are covered in full.
<b>Diagnostic Lab and X-ray Services</b>	<b>Inpatient:</b> Covered under Hospital Services. <b>Outpatient:</b> Deductible and co-insurance apply. High-end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.	<b>Inpatient:</b> Covered under Hospital Services. <b>Outpatient:</b> Deductible and co-insurance apply. High-end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.
<b>Emergency Services (Co-pay Waived if Admitted)</b>	\$150 co-pay. Deductible and co-insurance apply.	\$150 co-pay. In-network deductible and in-network co-insurance apply.

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## (CONT'D) EFFECTIVE 1/1/2019

BENEFITS	INSIDE NETWORK	OUT-OF-NETWORK
Hearing Exams (Routine)	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Hearing Hardware	\$400 per ear every 36 months.	Benefit shared with in-network.
Home Health Services	Covered in full. No visit limit.	Deductible and co-insurance apply. No visit limit.
Hospice Services	Covered in full. No visit limit.	Deductible and co-insurance apply. No visit limit.
Infertility Services	50% diagnostic services & drugs, deductible and co-insurance apply.	Benefits shared with in-network.
Manipulative Therapy	Self-referred up to 20 visits per calendar year. Deductible and co-insurance apply.	Visit limit shared with in-network. Deductible and co-insurance apply.
Massage Services	See Rehabilitation services.	See Rehabilitation services.
Maternity Services	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.
Mental Health	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.
Naturopathy Services	Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan. Deductible and co-insurance apply.	Deductible and co-insurance apply. No visit limit.
Obesity-Related Surgery (Bariatric)	Covered at cost shares when medical criteria is met.	Not covered.
Organ Transplants Donor Search & Harvest	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.
Preventive Care Well-care physicals, immunizations, Pap smear exams, mammograms	Women's preventive care services (including contraceptive drugs, devices, and sterilization) are covered in full.	Women's preventive care services (including contraceptive drugs, devices, and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply.
Rehabilitation Services (Occupational, Speech and Physical Including Services for Neurodevelopmentally Disabled Members). Rehabilitation Visits are a Total of Combined Therapy Visits Per Calendar Year.	<b>Inpatient:</b> 60 days per condition per calendar year, deductible and co-insurance apply. <b>Outpatient:</b> 60 visits per condition per calendar year. Deductible and co-insurance apply.	<b>Inpatient:</b> Day limit shared with in-network. Deductible and co-insurance apply. <b>Outpatient:</b> Visit limit shared with in-network. Deductible and co-insurance apply.
Skilled Nursing Facility	Up to 60 days per calendar year, deductible and co-insurance apply.	Day limit shared with in-network benefit, deductible and co-insurance apply.
Sterilization (Vasectomy, Tubal Ligation)	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply. Women's sterilization procedures are covered in full.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply. Women's sterilization procedures are subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) Services	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.	<b>Inpatient:</b> Deductible and co-insurance apply. <b>Outpatient:</b> Deductible and co-insurance apply.
Tobacco Cessation See Pharmacy Benefit for Associated Drug Coverage	Quit for Life Program—covered in full.	Applicable cost shares apply.
Routine Vision Care (1 Visit Every 12 Months)	Deductible and co-insurance waived.	Deductible and co-insurance apply.
Optical Hardware Lenses, including contact lenses and frames	Not subject to deductible and co-insurance. Members age 19 and over limited to \$165 per 24 months. Members under age 19 limited to 1 pair of frames and lenses per year.	Benefit limits shared with in-network.