Medical Plan Benefit Summary

KAISER PERMANENTE®

HMO Plan Summary
Effective Date: 08/01/2021

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage. In accordance with the Patient Protection and Affordable Care Act of 2010:

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan.

Benefits	Inside Network
Plan deductible	No annual deductible
Individual deductible carryover	Not applicable
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	**Individual out-of-pocket limit**: $1,200 **Family out-of-pocket limit:** $2,400 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) waiting period	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	No co-pay primary/$15 co-pay specialty
Hospital services	**Inpatient services**: $100 co-pay, per day for up to 5 days per admit **Outpatient surgery**: $50 co-pay
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Value based/preferred generic (Tier 1)/preferred brand (Tier 2) $4/$8/$25 co-pay per 30 day supply
Prescription mail order	$5 discount per 30 day supply
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan - $15 co-pay
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** $100 co-pay, per day for up to 5 days per admit **Outpatient:** $0 co-pay
Devices, equipment and supplies New this year: Deductible waived on diabetic supplies" and "Home phototherapy equipment is fully covered	Covered at 50% • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies—see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.

Kaiser Permanente of Washington HMO Health Plan Benefit Summary, continued.

Benefits	Inside Network
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Covered in full, MRI/PET/CT $50 co-pay High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (co-pay waived if admitted)	$200 co-pay at a designated facility $200 co-pay at a non-designated facility
Hearing exams (routine)	$0 co-pay
Hearing hardware	Covered through a separate benefit: EPIC Hearing. No co-pay, up to $1,200 per ear every 3 years toward the cost of a hearing aid. Learn more at myseiu.be/hearing.
Home health services	Covered in full. No visit limit. Pre-authorization required or will not be covered.
Hospice services	Covered in full
Infertility services	Medical and surgical services for the treatment of sterility and infertility and all related services, including artificial insemination, in-vitro fertilization and drug therapy are covered subject to the applicable outpatient services cost shares, limited to $50,000 per lifetime maximum. Fertility drugs are covered subject to deductible and 20% plan coinsurance, limited to a lifetime maximum of $5,000
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization - $0 co-pay.
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** $100 co-pay, per day for up to 5 days per admit **Outpatient:** $0 co-pay. Routine care not subject to outpatient services co-pay.
Mental Health	**Inpatient:** $100 co-pay, per day for up to 5 days per admit. Pre-authorization required or will not be covered. **Outpatient:** $0 co-pay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $15 co-pay
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity Related Services	Covered at cost shares when medical criteria is met
Organ transplants	Unlimited, no waiting period **Inpatient**: $100 co-pay, per day for up to 5 days per admit **Outpatient:** $0 co-pay
Preventive care: Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.
Rehabilitation services: Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 60 days per calendar year. Services with mental health diagnoses are covered with no limit. $100 co-pay, per day for up to 5 days per admit. Pre-authorization required or will not be covered. **Outpatient**: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit. No co-pay primary/$15 co-pay specialty
Skilled nursing facility	Covered in full up to 60 days per calendar year
Sterilization (vasectomy, tubal ligation)	Covered in full.
Temporomandibular Joint (TMJ) services	**Inpatient:** $100 co-pay, per day for up to 5 days per admit **Outpatient:** $0 co-pay
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$0 co-pay
Optical hardware: Lenses, including contact lenses and frames	Members under 19: 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance Members age 19 and over: $300 per 12 months