Benefit Summary

City of Seattle - Police LEOFF 1 & 2 Early Retirees - Deductible Plan Group Number: 1179200

KAISER PERMANENTE®

Effective Date 1/1/2019	**Health Plan** Core HMO	**Ref** RQ-130063

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, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Kaiser Permanente believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010. Questions regarding this status may be directed to Member Services (888) 901-4636. You may also contact the Employee Benefits Security Administration, U.S.Department of Labor at (866) 444-3272 or http://www.dol.gov/ebsa/healthreform.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $200 per calendar year Family deductible: $600 per calendar year
Individual deductible carryover	4th quarter carryover applies
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	Individual out-of-pocket limit: $2,000 Family out-of-pocket limit: $6,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Outpatient services, emergency services at a Managed Health Care Network (MHCN) or non-MHCN facility and ambulance services.
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$20 copay, deductible applies
Hospital services	**Inpatient services:** Deductible applies **Outpatient surgery:** $20 copay, deductible applies
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand $15/$30 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $20 copay, deductible applies
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible applies **Outpatient:** $20 copay, deductible applies
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%

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.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible applies High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$75 copay at a designated facility $125 copay at a non designated facility Deductible applies
Hearing exams (routine)	$20 copay, deductible applies
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $20 copay, deductible applies
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible applies **Outpatient:** $20 copay, deductible applies. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible applies **Outpatient:** $20 copay, deductible applies
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $20 copay, deductible applies
Newborn Services	Any applicable coinsurance applies to the newborn while both mother and baby are confined. Otherwise, all applicable inpatient cost shares apply. Office visits: See Outpatient Services; Routine well care: See Preventive care.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible applies **Outpatient:** $20 copay, deductible applies
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	$20 copay (deductible waived) 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. Deductible applies **Outpatient:** 60 visits per calendar year. Services with mental health diagnoses are covered with no limit. $20 copay, deductible applies
Skilled nursing facility	Up to 60 days per calendar year, deductible applies
Sterilization (vasectomy, tubal ligation)	**Inpatient:** Deductible applies **Outpatient:** $20 copay, deductible applies **Outpatient Surgery:** See Hospital services; Outpatient surgery section
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible applies **Outpatient:** $20 copay, deductible applies
Tobacco cessation counseling	Covered in full
Routine vision care (1 visit every 12 months)	$20 copay, deductible waived
Optical hardware Lenses, including contact lenses and frames	Not covered