

Effective Date 1/1/2017 Health Plan Access PPO Ref RQ-108550

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.

Benefits	Preferred Provider Network	Out-of-Network
Plan deductible	Individual deductible: \$5,000 per calendar year Family deductible: \$10,000 per calendar year	Individual deductible: \$10,000 per calendar year Family deductible: \$20,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 50%, you pay 50%	Plan pays 50%, you pay 50% of the Allowed Amount.
	Individual out-of-pocket limit: \$7,150 Family out-of-pocket limit: \$14,300	Individual out-of-pocket limit: \$14,300 Family out-of-pocket limit: \$28,600
Out-of-pocket limit	Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:	Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:
	All cost shares for covered services	All cost shares for covered services
Pre-existing condition (PEC) waiting period	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	\$25 copay (\$15 copay enhanced benefit), deductible and coinsurance apply Enhanced benefit applies when services are provided by an Enhanced provider.	No copay, deductible and coinsurance apply
Hospital services	Inpatient services: Deductible and coinsurance apply Outpatient surgery: Deductible and coinsurance apply	Inpatient services: Deductible and coinsurance apply Outpatient surgery: Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred \$20/\$45/\$65 (\$20/\$40/\$60 enhanced) copay up to a 30 day supply.	Preferred generic/preferred brand/non-preferred Not covered
Prescription mail order	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
Acupuncture	Covered up to 12 visits per calendar year \$25 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Chemical dependency	Inpatient: Deductible and coinsurance apply Outpatient: \$25 copay (\$15 copay enhanced benefit), deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: No copay, deductible and coinsurance apply
Devices, equipment and supplies		
 Durable medical equipment Orthopedic appliances Post-mastectomy bras limited to two (2) every six (6) months Ostomy supplies Prosthetic devices 	Deductible and coinsurance apply	Deductible and coinsurance apply

Diagnostic lab and X-ray services Diagnostic lab and X-ray services	to 8 visits per calendar year without prior additional visits when approved by the plan	diabetic supplies are not subject to these limits. Inpatient: Covered under Hospital services Outpatient: Deductible and coinsurance apply 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. \$250 copay Preferred provider deductible and coinsurance apply No copay, deductible and coinsurance apply Not covered No visit limit Deductible and coinsurance apply Deductible and coinsurance apply
Emergency services (copay waived if admitted) Hearing exams (routine) Hearing hardware Home health services Hospice services Infertility services Manipulative therapy Massage services Maternity services Mental Health Mental Health Naturopathy Newborn Services Not covered Inpatient:	e determined Medically Necessary and require zation except when associated with Emergency tient services. and coinsurance apply \$15 copay enhanced benefit), deductible and apply and coinsurance apply to 8 visits per calendar year without prior n; additional visits when approved by the plan	PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services. \$250 copay Preferred provider deductible and coinsurance apply No copay, deductible and coinsurance apply Not covered No visit limit Deductible and coinsurance apply Deductible and coinsurance apply
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Hospice services Infertility services Manipulative therapy Massage services Maternity services Maternity services Mental Health Naturopathy Newborn Services Covered up authorization \$25 copay, Massage services Inpatient: Inp	to 8 visits per calendar year without prior n; additional visits when approved by the plan	Deductible and coinsurance apply Deductible and coinsurance apply
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Manipulative therapy Covered up authorization \$25 copay, Massage services See Rehab Inpatient:	to 8 visits per calendar year without prior n; additional visits when approved by the plan	Not covered
Manipulative therapy authorization \$25 copay, Massage services Maternity services Mental Health Mental Health Naturopathy Newborn Services Obesity-related surgery (bariatric) Organ transplants Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms Rehabilitation visits are a total Maternity services Inpatient: Inpati	n; additional visits when approved by the plan	Not covered
Maternity services Inpatient: In	deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Maternity services Outpatient deductible a to outpatient Inpatient: I Outpatient deductible a deductible a deductible a deductible a services Naturopathy Newborn Services Initial hosping Outpatient Any application that of Obesity-related surgery (bariatric) Organ transplants Inpatient: I Outpatient Outpatient Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms Covered in Women's particular drugs and control outpatient Rehabilitation services Rehabilitation visits are a total Inpatient: Courted in Women's particular drugs and control outpatient	itation services	See Rehabilitation services
Mental Health Naturopathy Newborn Services Newborn Services Obesity-related surgery (bariatric) Not covered in the covere	seductible and coinsurance apply \$25 copay (\$15 copay enhanced benefit), nd coinsurance apply. Routine care not subject services copay.	Inpatient: Deductible and coinsurance apply Outpatient: No copay, deductible and coinsurance apply
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Newborn Services Outpatient and Any application that of Any application that of Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms Covered in Women's particular drugs and content of the Any application that of Any application that of Preventive Covered in Women's particular drugs and content of the Any application that of the Any application that of the Any application that of An	deductible and coinsurance apply	No copay, deductible and coinsurance apply
(bariatric) Organ transplants Unlimited, r Unlimited, r Outpatient: Covered in Well-care physicals, immunizations, Pap smear exams, mammograms Women's p drugs and comparison of the comparison of the comparison of the comparison of the covered in the comparison of the comparison of the covered in the comparison of the covered in	al stay: See Hospital Services; Office visits: See Services; Routine well care: See Preventive care. ole cost share for newborn services is separate the mother.	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.
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms Rehabilitation services Rehabilitation visits are a total Inpatient: 1 Women's p drugs and of the large physicals in the large physicals in the large physicals in the large physical p		Not covered
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms Rehabilitation services Rehabilitation visits are a total Inpatient: 0 Unpatient: 0 Inpatient: 0 Health diagnorms	o waiting period	Shared with preferred provider network
Well-care physicals, immunizations, Pap smear exams, mammograms Rehabilitation services Rehabilitation visits are a total Women's p drugs and of the services health diagonal polysical	eductible and coinsurance apply \$25 copay, deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: No copay, deductible and coinsurance apply
Well-care physicals, immunizations, Pap smear exams, mammograms Rehabilitation services Rehabilitation visits are a total Women's p drugs and of the services health diagonal polysical		Deductible and coinsurance apply
Rehabilitation services health diagnost Deductible Rehabilitation visits are a total Outpatient	ull eventive care services (including contraceptive evices and sterilization) are covered in full.	Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums.
Rehabilitation services health diagnost Deductible Rehabilitation visits are a total Outpatient	,	Routine mammograms: Deductible and coinsurance apply
	·	Inpatient: Day limits shared with preferred provider network Deductible and coinsurance apply Outpatient: Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Skilled nursing facility Up to 60 da apply	O days per calendar year. Services with mental oses are covered with no limit. and coinsurance apply 45 visits per calendar year. Services with mental oses are covered with no limit. \$15 copay enhanced benefit), deductible and	
Sterilization (vasectomy, tubal ligation) Inpatient: I Outpatient Women's si	O days per calendar year. Services with mental oses are covered with no limit. and coinsurance apply 45 visits per calendar year. Services with mental oses are covered with no limit. \$15 copay enhanced benefit), deductible and	Day limits shared with preferred provider network, deductible and coinsurance apply

Temporomandibular Joint (TMJ) services	Inpatient: Deductible and coinsurance apply Outpatient: \$25 copay (\$15 copay enhanced benefit), deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	Covered in full	Covered in full
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered

All plans offered and underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.

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