

<b>Effective Date</b> 4/1/2020	<b>Health Plan</b> Access PPO	<b>Ref</b> RQ-148359
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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
<b>Plan deductible</b>	Individual deductible: \$1,000 per calendar year Family deductible: \$2,000 per calendar year	Shared with preferred provider network
<b>Individual deductible carryover</b>	4th quarter carryover does not apply	4th quarter carryover does not apply
<b>Plan coinsurance</b>	Plan pays 80%, you pay 20%	Plan pays 50%, you pay 50% of the Allowed Amount.
<b>Deductible and/or coinsurance waiver riders</b>	Deductible and coinsurance do not apply to outpatient visits; in-network only (excludes lab/xray)	Not applicable
<b>Out-of-pocket limit</b>	Individual out-of-pocket limit: \$6,600 Family out-of-pocket limit: \$13,200  Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:  All cost shares for covered services	Shared with preferred provider network  Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:  All cost shares for covered services
<b>Pre-existing condition (PEC) waiting period</b>	No PEC	Same as preferred provider network
<b>Lifetime maximum</b>	Unlimited	Shared with preferred provider maximum
<b>Outpatient services (Office visits)</b>	\$30 copay (\$20 copay enhanced benefit) primary/\$60 copay (\$40 copay enhanced benefit) specialty Enhanced benefit applies when services are provided by an Enhanced provider.	No copay primary/No copay specialty, deductible and coinsurance apply
<b>Hospital services</b>	<b>Inpatient services:</b> Deductible and coinsurance apply <b>Outpatient surgery:</b> Deductible and coinsurance apply	<b>Inpatient services:</b> Deductible and coinsurance apply <b>Outpatient surgery:</b> Deductible and coinsurance apply
<b>Prescription drugs (some injectable drugs may be covered under Outpatient services)</b>	Preferred generic/preferred brand/non-preferred/preferred specialty \$15/\$25/\$45 (\$5/\$15/\$35 enhanced) copay and 50% up to \$150 for preferred Specialty drugs up to a 30 day supply.	Not covered
<b>Prescription mail order</b>	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
<b>Acupuncture</b>	Covered up to 12 visits per calendar year \$30 copay	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
<b>Ambulance services</b>	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
<b>Chemical dependency</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$30 copay (\$20 copay enhanced benefit)	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply
<b>Devices, equipment and supplies</b>  <ul style="list-style-type: none"> <li>• Durable medical equipment</li> <li>• Orthopedic appliances</li> <li>• Post-mastectomy bras limited to two (2) every six (6) months</li> <li>• Ostomy supplies</li> <li>• Prosthetic devices</li> </ul>	Deductible and coinsurance apply	Deductible and coinsurance apply

<b>Diabetic supplies</b>	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.	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.
<b>Diagnostic lab and X-ray services</b>	<b>Inpatient:</b> Covered under Hospital services <b>Outpatient:</b> Deductible and coinsurance apply  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.	<b>Inpatient:</b> Covered under Hospital services <b>Outpatient:</b> Deductible and coinsurance apply  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.
<b>Emergency services</b> (copay waived if admitted)	\$100 copay Deductible and coinsurance apply	\$100 copay Preferred provider deductible and coinsurance apply
<b>Hearing exams (routine)</b>	\$30 copay (\$20 copay enhanced benefit)	No copay, deductible and coinsurance apply
<b>Hearing hardware</b>	Not covered	Not covered
<b>Home health services</b>	Covered at deductible and coinsurance up to 130 visits total per calendar year	Visit limit shared with preferred provider network Deductible and coinsurance apply
<b>Hospice services</b>	Deductible and coinsurance apply	Deductible and coinsurance apply
<b>Infertility services</b>	Not covered	Not covered
<b>Manipulative therapy</b>	Covered up to 15 visits per calendar year without prior authorization; additional visits when approved by the plan \$30 copay	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
<b>Massage services</b>	See Rehabilitation services	See Rehabilitation services
<b>Maternity services</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$30 copay (\$20 copay enhanced benefit). Routine care not subject to outpatient services copay.	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply
<b>Mental Health</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$30 copay (\$20 copay enhanced benefit)	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply
<b>Naturopathy</b>	\$30 copay	No copay, deductible and coinsurance apply
<b>Newborn Services</b>	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.	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.
<b>Obesity-related surgery (bariatric)</b>	Not covered	Not covered
<b>Organ transplants</b>	Unlimited, no waiting period  <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$30 copay	Shared with preferred provider network  <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply
<b>Preventive care</b> Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full  Women's contraception is covered as preventive, and Men's contraception is covered in full	Deductible and coinsurance apply  Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums.  Routine mammograms: Deductible and coinsurance apply
<b>Rehabilitation services</b>  Rehabilitation visits are a total of combined therapy visits per calendar year	<b>Inpatient:</b> 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply <b>Outpatient:</b> 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. \$30 copay (\$20 copay enhanced benefit) primary/\$60 copay (\$40 copay enhanced benefit) specialty	<b>Inpatient:</b> Day limits shared with preferred provider network Deductible and coinsurance apply <b>Outpatient:</b> Visit limits shared with preferred provider network No copay primary/No copay specialty, deductible and coinsurance apply
<b>Skilled nursing facility</b>	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with preferred provider network, deductible and coinsurance apply
<b>Sterilization</b> (vasectomy, tubal ligation)	Covered in full	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply <b>Outpatient Surgery:</b> See Hospital services; Outpatient surgery section  Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.

<b>Temporomandibular Joint (TMJ) services</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$30 copay (\$20 copay enhanced benefit)	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply
<b>Tobacco cessation counseling</b>	Quit for Life Program - covered in full	Applicable cost shares apply
<b>Routine vision care</b> (1 visit every 12 months)	Covered in full	Covered in full
<b>Optical hardware</b> 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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