Health Plan Benefit Summary

Washington POS Plan Summary

Effective Date: 8/1/2019

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.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Inside Network</th>
<th>Outside Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan deductible</td>
<td>No annual deductible</td>
<td>Individual deductible: $500 per calendar year</td>
</tr>
<tr>
<td>Individual deductible carryover</td>
<td>Not applicable</td>
<td>4th quarter carryover applies</td>
</tr>
<tr>
<td>Plan coinsurance</td>
<td>No plan coinsurance</td>
<td>Plan pays 80%, you pay 20% of the Allowed Amount</td>
</tr>
<tr>
<td>Out-of-pocket limit</td>
<td>Individual out-of-pocket limit: $1,200</td>
<td>Out-of-pocket limit is shared with in-network</td>
</tr>
<tr>
<td></td>
<td>Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services</td>
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</tr>
<tr>
<td>Pre-existing condition (PEC) waitng period</td>
<td>No PEC</td>
<td>Same as in-network</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>Unlimited</td>
<td>Same as in-network maximum</td>
</tr>
<tr>
<td>Outpatient services (Office visits)</td>
<td>$15 co-pay</td>
<td>$15 co-pay, deductible and coinsurance apply</td>
</tr>
<tr>
<td>Hospital services</td>
<td><strong>Inpatient services: $100 co-pay, per day for up to 5 days per admit</strong></td>
<td><strong>Inpatient services: $100 co-pay, per day for up to 5 days per admit</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient surgery: $50 co-pay</strong></td>
<td>Outpatient surgery: $50 co-pay, deductible and coinsurance apply</td>
</tr>
<tr>
<td>Prescription drugs (some injectable drugs may be covered under Outpatient services)</td>
<td>Value based/preferred generic (Tier 1)/preferred brand (Tier 2)/non-preferred (Tier 3) $4/$8/$25/$50 co-pay per 30 day supply</td>
<td>Preferred generic/preferred brand/non-preferred $13/$30/$55 co-pay per 30 day supply</td>
</tr>
<tr>
<td>Prescription mail order</td>
<td>$5 discount per 30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan – $15 co-pay</td>
<td>$15 co-pay, deductible and coinsurance apply</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>Plan pays 80%, you pay 20%</td>
<td>Same as in-network</td>
</tr>
<tr>
<td>Chemical dependency</td>
<td><strong>Inpatient: $100 co-pay, per day for up to 5 days per admit</strong></td>
<td><strong>Inpatient: $100 co-pay, per day for up to 5 days per admit</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient: $0 co-pay</strong></td>
<td>Deductible and coinsurance apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient: $15 co-pay, deductible and coinsurance apply</td>
</tr>
</tbody>
</table>
### Benefits | Inside Network | Outside Network
--- | --- | ---
**Devices, equipment and supplies** | Covered at 50%  
- Durable medical equipment  
- Orthopedic appliances  
- Post-mastectomy bras limited to two (2) every six (6) months  
- Ostomy supplies  
- Prosthetic devices | Covered at 50%, deductible applies

**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. | 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**: Covered in full  
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. | **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.

**Emergency services (co-pay waived if admitted)** | $200 co-pay | $200 co-pay

**Hearing exams (routine)** | $15 co-pay | $15 co-pay, deductible and coinsurance apply

**Hearing hardware** | Not covered | Not covered

**Home health services** | Covered in full. No visit limit. | No visit limit  
Deductible and coinsurance apply

**Hospice services** | Covered in full | Deductible and coinsurance apply

**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 | Not covered

**Manipulative therapy** | Covered up to 10 visits per calendar year without prior authorization  
$15 co-pay | Visit limits shared with in-network  
$15 co-pay, deductible and coinsurance apply

**Massage services** | See Rehabilitation services | See Rehabilitation services

**Maternity services** | **Inpatient**: $100 co-pay, per day for up to 5 days per admit  
**Outpatient**: $15 co-pay. Routine care not subject to outpatient services co-pay. | **Inpatient**: $100 co-pay, per day for up to 5 days per admit  
Deductible and coinsurance apply  
**Outpatient**: $15 co-pay, deductible and coinsurance apply.  
Routine care not subject to outpatient services co-pay.

**Mental Health** | **Inpatient**: $100 co-pay, per day for up to 5 days per admit  
**Outpatient**: $0 co-pay | **Inpatient**: $100 co-pay, per day for up to 5 days per admit  
Deductible and coinsurance apply  
**Outpatient**: $15 co-pay, deductible and coinsurance apply.
### Kaiser Permanente of Washington POS Health Plan Benefit Summary, continued

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<th>Benefits</th>
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<tr>
<td><strong>Newborn Services</strong></td>
<td><strong>Initial hospital stay</strong>: 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.</td>
<td><strong>Initial hospital stay</strong>: 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.</td>
</tr>
<tr>
<td><strong>Obesity Related Services</strong></td>
<td>Covered at cost shares when medical criteria is met</td>
<td>Covered at cost shares when medical criteria is met</td>
</tr>
</tbody>
</table>
| **Organ transplants**        | Unlimited, no waiting period  
**Inpatient**: $100 co-pay, per day for up to 5 days per admit  
**Outpatient**: $15 co-pay | Shared with in-network  
**Inpatient**: $100 co-pay, per day for up to 5 days per admit  
Deductible and coinsurance apply  
**Outpatient**: $15 co-pay, deductible and coinsurance apply |
| **Preventive care**          | Covered in full  
Women’s preventive care services (including contraceptive drugs and devices and sterilization) are 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 |
| **Rehabilitation services**  | **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  
**Outpatient**: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit.  
$15 co-pay | **Inpatient**: Day limits shared with in-network  
$100 co-pay, per day for up to 5 days per admit  
Deductible and coinsurance apply  
**Outpatient**: Visit limits shared with in-network  
$15 co-pay, deductible and coinsurance apply |
| **Skilled nursing facility** | Covered in full up to 60 days per calendar year | Day limits shared with in-network benefit, deductible and coinsurance apply |
| **Sterilization**            | **Inpatient**: $100 co-pay, per day for up to 5 days per admit  
**Outpatient**: $15 co-pay  
Women’s sterilization procedures are covered in full. | **Inpatient**: $100 co-pay, per day for up to 5 days per admit  
Deductible and coinsurance apply  
**Outpatient**: $15 co-pay, deductible and coinsurance apply  
Women’s sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums. |
| **Temporomandibular Joint (TMJ) services** | **Inpatient**: $100 co-pay, per day for up to 5 days per admit  
**Outpatient**: $15 co-pay | **Inpatient**: $100 co-pay, per day for up to 5 days per admit  
Deductible and coinsurance apply  
**Outpatient**: $15 co-pay, deductible and coinsurance apply |
| **Tobacco cessation counseling** | Quit for Life Program – covered in full | Applicable cost shares apply |
| **Routine vision care**      | $15 co-pay | $15 co-pay, deductible and coinsurance apply |
| **Optical hardware**         | **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 | Shared with in-network |