

Benefit Summary

City Of Seattle

Group Number: 0284900



Effective Date 1/1/2025	Health Plan Core HMO	Ref RQ-202339
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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.

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	No annual deductible
Individual deductible carryover	Not applicable
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	Individual out-of-pocket limit: \$2,000 Family out-of-pocket limit: \$4,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Plan coinsurance, emergency services at a Managed Health Care Network (MHCN) facility and ambulance services.
Pre-existing condition (PEC) waiting period	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	\$15 copay
Hospital services	Inpatient services: \$200 copay, per admit Outpatient surgery: \$15 copay
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	3 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 \$15 copay
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	Inpatient: \$200 copay, per admit Outpatient: \$15 copay

Devices, equipment and supplies <ul style="list-style-type: none"> • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices 	Covered at 80%, orthotic devices are covered up to a \$500 maximum per lifetime
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: Covered in full 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)	\$100 copay at a designated facility \$100 copay at a non designated facility
Hearing exams (routine)	\$15 copay
Hearing hardware	\$3,000 per ear every 36 months
Home health services	\$1,000 per ear every 36 months No visit limit.
Hospice services	Covered in full
Infertility services	Covered for general counseling and diagnostic services, subject to the applicable outpatient services cost share. All fertility treatments are limited to \$20,000 medical lifetime maximum. Fertility drugs are covered subject to rx cost shares. (Lifetime limit does not apply to drug therapy). Specific diagnostic services, medical and surgical treatment, artificial insemination Services related to conception by artificial insemination, in-vitro fertilization, and assisted reproduction, including gamete intrafallopian transfer (GIFT) and zygote intrafallopian (ZIFT) are covered subject to applicable cost share(s). Fertility Preservation Services (Freezing of eggs, sperm, and/or fertilized embryos including storage costs) and donor sperm/eggs are covered subject to the applicable cost share(s) limited to 12 cycles per lifetime maximum. Fertility preservation services for Iatrogenic infertility, such as retrieval of sperm and eggs, cryopreservation, and storage for preserved specimen for up to 12 months after a covered preservation procedure is covered subject to the applicable cost shares
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization \$15 copay
Massage services	See Rehabilitation services
Maternity services	Inpatient: \$200 copay, per admit Outpatient: \$15 copay. Routine care not subject to outpatient services copay.
Mental Health	Inpatient: \$200 copay, per admit Outpatient: \$15 copay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$15 copay
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)	Covered at cost shares when medical criteria is met

Organ transplants	<p>Unlimited, no waiting period</p> <p>Inpatient: \$200 copay, per admit</p> <p>Outpatient: \$15 copay</p>
<p>Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms</p>	<p>\$15 copay</p> <p>Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full</p>
<p>Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year</p>	<p>Inpatient: 60 days per calendar year. Services with mental health diagnoses are covered with no limit. \$200 copay, per admit</p> <p>Outpatient: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit. \$15 copay</p>
Skilled nursing facility	Covered in full up to 60 days per calendar year
<p>Sterilization (vasectomy, tubal ligation)</p>	<p>Inpatient: \$200 copay, per admit</p> <p>Outpatient: \$15 copay Outpatient Surgery: See Hospital services; Outpatient surgery section</p> <p>Women's sterilization procedures are covered in full.</p>
Temporomandibular Joint (TMJ) services	<p>Inpatient: \$200 copay, per admit</p> <p>Outpatient: \$15 copay</p>
Tobacco cessation counseling	Covered in full
<p>Routine vision care (1 visit every 12 months)</p>	\$15 copay
<p>Optical hardware Lenses, including contact lenses and frames</p>	Not covered
<p>Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)</p>	Covered in full