BENEFIT COMPARISON — ACTIVES AND NON-MEDICARE ELIGIBLE RETIREES
Plan Year: January 1, 2019 — December 31, 2019

	Self-Insured Plan	Kaiser HMO
PHYSICIAN SERVICES		
Primary	Major Medical	$0 copay per visit
Specialist	Major Medical	$0 copay per visit; referrals required
OUTPATIENT SERVICES		
Diagnostic Lab and Radiology	Major Medical	No copay for diagnostic lab or radiology services including specialty imaging; certain radiology procedures require prior authorization
Surgical Services	Major Medical	$0 copay at Kaiser Permanente ambulatory surgery units; $0 copay at hospital outpatient facilities (certain procedures require prior authorization)
Emergency Care		
In Service Area	Major Medical	$0 copay at urgent care centers; $100 copay at ER; covered only for services that meet the plan definition of Emergency Services; ER copay waived if member is admitted to the Hospital.
Out of Service Area	Same as in-service area	Same as in-service area; must meet emergency definition
Ambulance	Major Medical	Covered in full if Medically Necessary
Home Health Services	Major Medical	Covered in full; requires prior authorization
Physical Therapy	Major Medical; limited to 50 visits per year, combined with Speech and Occupational Therapy/Chiropractic	$0 copay per visit; limited to 30 visits per episode of treatment for PT
Speech/Occupational Therapy	Major Medical; see note for Physical Therapy re: limit on visits/year	$0 copay per visit; limited to 30 visits per episode of treatment for ST/OT
Podiatry/Chiropractic	Major Medical; see note for Physical Therapy re: limit on visits/year	Chiropractic care: $0 copay up to 30 visits per year. Podiatry: $0 copay; no limit on visits.
INPATIENT SERVICES		
Room and Board (Semi-private) (including intensive care)	Major Medical	Covered in full; requires prior authorization

BENEFIT COMPARISON — ACTIVES AND NON-MEDICARE ELIGIBLE RETIREES
Plan Year: January 1, 2019 — December 31, 2019

	Self-Insured Plan	Kaiser HMO
Surgical Services	Major Medical	Covered in full; requires prior authorization
INPATIENT SERVICES (continued)		
Diagnostic Lab and Radiology	Major Medical	Covered in full
Skilled Nursing Facility (semi-private)	Major Medical	Covered in full (limited to 100 days per plan year); requires prior authorization
Hospice Care	Major Medical	Covered in full; requires prior authorization
MATERNITY SERVICES		
Physician Services (pre and post natal)	Major Medical	$0 copayment for initial visit; no copayments for subsequent visits
Inpatient Hospital Services	Major Medical	Covered in full (requires notification)
MENTAL HEALTH SERVICES		
Inpatient	Major Medical	Covered in full; requires prior authorization
Outpatient	Major Medical	$0 copay per visit for individual therapy; $0 copay for group therapy
SUBSTANCE ABUSE SERVICES		
Inpatient	Major Medical	Covered in full; requires prior authorization
Outpatient	Major Medical	$0 copay per visit
PREVENTIVE SERVICES		
Physical Exams	Covered in full	Covered in full
Adult Immunizations	Limited coverage is available	Limited coverage is available with no copay; see preventive guidelines
Well Baby Care (incl. immunizations)	Covered in full per schedule	Covered in full
Vision Screening	Not Covered	$0 copay; limit one pediatric visit per year under age 19; $0 copay for adult screening
Routine GYN Exam	Covered in Full	Covered in full

BENEFIT COMPARISON — ACTIVES AND NON-MEDICARE ELIGIBLE RETIREES
Plan Year: January 1, 2019 — December 31, 2019

	Self-Insured Plan	Kaiser HMO
OTHER SERVICES		
Infertility Testing/Treatments	Not covered	50% coinsurance
Artificial Insemination	Not covered	Not covered
Invitro Fertilization	Not covered	50% coinsurance (limited to 3 attempts per live birth, not to exceed a maximum lifetime limit of $100,000; certain criteria must be met)
DME/Prosthetic Devices	Major Medical	No copayment for durable medical equipment; No charge for prosthetic and orthotic devices
Organ Transplants	Non-experimental transplant covered under Major Medical	Non-Experimental only; covered in full after applicable copays; requires prior authorization

NOTE: ALL ELIGIBLE PARTICIPANTS ARE COVERED UNDER THE SEPARATE DENTAL PLAN

BENEFIT COMPARISON — ACTIVES AND NON-MEDICARE ELIGIBLE RETIREES
Plan Year: January 1, 2019 — December 31, 2019

	Self-Insured Plan	Kaiser HMO
PRESCRIPTION DRUGS		
Generic	$15 copay per fill	$0 copay per fill at KP Pharmacy, $15 copay at Network Pharmacy
Brand-Name, Formulary	$35 copay per fill	$25 copay per fill at KP pharmacy, $35 copay at Network Pharmacy
Brand-Name, Non-Formulary	$50 copay per fill	$50 copay per fill at KP pharmacy, $60 copay at Network Pharmacy
Mail Order (90 day supply)	2 copayments per 90 day supply; mandatory for maintenance drugs after second presctiption	2 copayments per 90 day supply*
Require use of Formulary List	Yes	Yes
Injectible Drugs	Covered on same basis for a limited list of drugs	Same copays as any other drug
Annual Maximum	No maximum	No maximum ***Note:*** ancillary charge applies when generic is available; certain drugs require prior authorization
OUT OF POCKET LIMIT		
Annual Maximum per Plan Year	Separate for Medical and Prescription Medical: $600 single/$1,200 family; Prescription: $5,800 single/$11,600 family	Combined for Medical and Prescription. $1,000 single/$2,000 family; includes all Medical and Prescription copays
MAJOR MEDICAL		
Annual Deductible	$100 Individual; $200 Family	N/A
Coinsurance	80% of the next $2,500	N/A
Annual Maximum	None	None