Benefit Summary

City of Spokane Local 270 Plan 3
Group Number: 4102600

KAISER PERMANENTE®

Effective Date 1/1/2025	**Health Plan** Core HMO	**Ref** RQ-198230

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	**Inside Network**
Plan deductible	Individual deductible: $200 per calendar year Family deductible: $400 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 90%, you pay 10%
Deductible and/or coinsurance waiver riders	Deductible and coinsurance do not apply to outpatient services
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: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$10 copay
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $25 copay
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand $10/$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 $10 copay
Ambulance services	Deductible and coinsurance
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $10 copay
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Coinsurance applies, deductible waived
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:** 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.
Emergency services (copay waived if admitted)	$100 copay at a designated facility $100 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$10 copay
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	50% diagnostic services & drugs, deductible and coinsurance apply
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $10 copay
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $10 copay. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $10 copay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $10 copay
Newborn Services	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.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $10 copay
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 60 days per calendar year. Services with mental health diagnoses are covered with no limit Deductible and coinsurance apply **Outpatient:** 60 visits per calendar year. Services with mental health diagnoses are covered with no limit $10 copay
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $10 copay **Outpatient Surgery:** See Hospital services; Outpatient surgery section Women's sterilization procedures are covered in full.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $10 copay
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$10 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	**Members under 19:** 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance **Members age 19 and over:** $50 per 24 months Not subject to deductible and coinsurance
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Covered in full