Benefit Summary

# Northwest Financial Association Employee Benefit Trust HMO 1000
# Group Number: SP01000

KAISER PERMANENTE®

| **Effective Date** 1/1/2023 | **Health Plan** Core HMO | **Ref** RQ-175106 |
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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** | **Inside Network** |
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| **Plan deductible** | Individual deductible: $1,000 per calendar year<br>Family deductible: $2,000 per calendar year |
| **Individual deductible carryover** | 4th quarter carryover applies |
| **Plan coinsurance** | Plan pays 80%, you pay 20% |
| **Deductible and/or coinsurance waiver riders** | 1st 4 visits per calendar year are not subject to deductible and/or coinsurance. Lab and xray services covered in full up to $500 per calendar year. |
| **Out-of-pocket limit** | Individual out-of-pocket limit: $5,000<br>Family out-of-pocket limit: $10,000<br><br>Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:<br><br>All cost shares for covered services |
| **Pre-existing condition** (PEC) **waiting period** | No PEC |
| **Lifetime maximum** | Unlimited |
| **Outpatient services** (Office visits) | $20 copay, deductible and coinsurance apply |
| **Hospital services** | **Inpatient services:** Deductible and coinsurance apply<br>**Outpatient surgery:** $20 copay, deductible and coinsurance apply |
| **Prescription drugs** (some injectable drugs may be covered under Outpatient services) | Preferred generic/preferred brand<br>$20/$40 copay per 30 day supply |
| **Prescription mail order** | 2 x prescription cost share per 90 day supply |
| **Acupuncture** | Covered up to 12 visits per calendar year<br>$20 copay, deductible and coinsurance apply |
| **Ambulance services** | Plan pays 80%, you pay 20% |
| **Chemical dependency** | **Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** $20 copay, deductible and coinsurance apply |
| **Devices, equipment and supplies**<br>• Durable medical equipment<br>• Orthopedic appliances<br>• Post-mastectomy bras limited to two (2) every six (6) months<br>• Ostomy supplies<br>• Prosthetic devices | Covered at 80% |
| **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<br>**Outpatient:** Covered in full up to $500 per calendar year, then deductible and coinsurance apply<br><br>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. |

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| **Emergency services** (copay waived if admitted) | $200 copay at a designated facility<br>$200 copay at a non designated facility<br>Deductible and coinsurance apply |
| **Hearing exams** (routine) | $20 copay, deductible and coinsurance apply |
| **Hearing hardware** | Not covered |
| **Home health services** | Covered in full. No visit limit. |
| **Hospice services** | Covered in full |
| **Infertility services** | Not covered |
| **Manipulative therapy** | Covered up to 10 visits per calendar year without prior authorization<br>$20 copay, deductible and coinsurance apply |
| **Massage services** | See Rehabilitation services |
| **Maternity services** | **Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** $20 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay. |
| **Mental Health** | **Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** $20 copay, deductible and coinsurance apply |
| **Naturopathy** | Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan<br>$20 copay, deductible and coinsurance apply |
| **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<br><br>**Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** $20 copay, deductible and coinsurance apply |
| **Preventive care**<br>Well-care physicals, immunizations, Pap smear exams, mammograms | Covered in full<br><br>Women's contraception is covered as preventive, and Men's contraception is covered in full |
| **Rehabilitation services**<br><br>Rehabilitation visits are a total of combined therapy visits per calendar year | **Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit.<br>Deductible and coinsurance apply<br>**Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit.<br>$20 copay, deductible and coinsurance apply |
| **Skilled nursing facility** | Up to 60 days per calendar year, deductible and coinsurance apply |
| **Sterilization** (vasectomy, tubal ligation) | Covered in full |
| **Temporomandibular Joint** (TMJ) **services** | **Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** $20 copay, deductible and coinsurance apply |
| **Tobacco cessation counseling** | Quit for Life Program - covered in full |
| **Routine vision care** (1 visit every 12 months) | $20 copay, deductible and coinsurance waived |
| **Optical hardware**<br>Lenses, including contact lenses and frames | Not covered |
| **Virtual Care**<br>Including Telemedicine, Telephone Services and Online (E-Visits) | Covered in full |