MEDICAL-AT-A-GLANCE COMPARISONS-shaded areas indicate changes

In case of conflict between this summary and the official plan documents, benefits will be paid according to the official documents.

Benefits Shown are In-Network ONLY***	PPO Plan 2 Access PPO or First Choice		PPO Plan 3 Access PPO or First Choice	
Services Received By	Kaiser Facility	In-Network	Kaiser Facility	In-Network
Deductible (individual/family)	$500 / $1,500 Per Calendar Year		$350 / $1,050 Per Calendar Year	
Out-of-Pocket Maximum (individual/family)	$3,500 (was $2,500) / $10,500 (was $7,500) Per Calendar Year		$4,000 / $12,000 Per Calendar Year	
Outpatient Services – Primary Care Office visits Specialist Office visits-Plan 2	$10 copay* (was $20) $20 copay*	$20 copay* (was $30) $40 copay* (was $30)	First 4 visits PCY: $20 copay* Thereafter: deductible then 20%	$30 copay*
Preventive Care	Covered in Full*		Covered in Full*	
Acupuncture & Spinal Manipulation	$20 copay* (was $30) per visit Acupuncture: up to 12 visits PCY Spinal Manipulation: unlimited		Covered under Outpatient Services Acupuncture: up to 12 visits PCY Spinal Manipulation: unlimited	
Outpatient Diagnostic X-ray & Lab	20%		Covered in Full* up to $500 PCY then: 20%	
Prescription Drug** 30-day supply	Kaiser Pharmacies	OptumRx Pharmacies	Kaiser Pharmacies	OptumRx Pharmacies
Generic - Preferred	$10 copay*	$10 copay*	$15 (was $10) copay*	$20 (was $10) copay*
Preferred - Brand Name	$30 copay*	$35 copay*	$45 (was $30) copay*	$50 (was $35) copay*
Non-Preferred - Brand Name	$65 copay*	$70 copay*	$85 (was $65) copay*	$95 (was $70) copay*
Mail Order - 90-day supply	2x copay*	Not Covered	2x copay*	Not Covered
Outpatient Surgery (facility/physician or surgeon)	20%		20%	
Emergency Room (copay waived if admitted)	$200 (was $100) copay per visit then 20%		$200 (was $100) copay per visit then 20%	
Hospital/Facility Services	$200 copay/day up to $600 per admit then 20%		$200 copay/day up to $1,000 (was $600) per admit then 20%	
Rehabilitation Services Inpatient	Covered under Hospital/Facility Services up to 60 days PCY		Covered under Hospital/Facility Services up to 60 days PCY	
Outpatient	Covered under Outpatient Services up to 60 visits PCY		Covered under Outpatient Services up to 60 visits PCY	

PCY = Per Calendar Year

* Deductible waived

** If you choose brand name drugs when generic equivalent is available, you will be responsible for the difference in cost between the brand name and the generic equivalent drugs.

*** Summary of out of network coverage is available on the Summary of Benefits and coverage (SBC). Please note that there is no out of network coverage for the HMO plan (except emergencies).

MEDICAL-AT-A-GLANCE COMPARISONS-shaded areas indicate changes

In case of conflict between this summary and the official plan documents, benefits will be paid according to the official documents.

HMO Kaiser Permanente	PPO Plan 7 Access PPO or First Choice		HDHP Access PPO or First Choice	
Kaiser Facility	Kaiser Facility	In-Network	Kaiser Facility	In-Network
$250 (was $200) / $750 (was $600) Per Calendar Year	$750 / $2,250 Per Calendar Year		$1,750 (was $1,500) / $3,500 (was $3,000) (aggregate) Per Calendar Year	
$1,500 (was $1,000) / $4,500 (was $3,000) Per Calendar Year	$4,000 / $12,000 Per Calendar Year		$6,550 (was$5,100) / $7,350 (was $7,150) (aggregate) Per Calendar Year	
$25 (was $20) copay then 20%	First 4 (was 6) visits PCY: $25 (was $20) copay*	$35 (was $30) copay* Thereafter: deductible then 30%	20% (was 10%)	30% (was 20%)
Covered in Full*	Covered in Full*		Covered in Full*	
Covered under Outpatient Services Acupuncture: up to 12 visits PCY Spinal Manipulation: 10 visits PCY	Covered under Outpatient Services Acupuncture: up to 12 visits PCY Spinal Manipulation: unlimited		Covered under Outpatient Services Acupuncture: up to 12 visits PCY Spinal Manipulation: unlimited	
20%	Covered in Full* up to $500 (was $800) PCY, then: 30%		30% (was 20%)	
Kaiser Pharmacies $10 copay* $20 copay* Not Covered 2x copay*	Kaiser Pharmacies $5 copay* $35 copay* $80 copay* 2x copay*	OptumRx Pharmacies $5 copay* $45 copay* $90 copay* Not Covered	Kaiser Pharmacies $10 copay $30 copay $65 copay 2x copay	OptumRx Pharmacies $10 copay $35 copay $70 copay Not Covered
$25 (was $20) copay then 20%	30%		30% (was 20%)	
$150 (was $100) copay per visit then 20%	$200 (was $150) copay per visit then 30%		$200 (was $100) copay per visit then 30% (was 20%)	
$100 per day up to $300 per admit (was $300 per admit) then 20%	$200 per day up to $600 per admit then 30%		30% (was 20%)	
Covered under Hospital/Facility up to 60 days PCY Covered under Outpatient up to 60 days PCY	Covered under Hospital/Facility Services up to 60 days PCY Covered under Outpatient Services up to 60 visits PCY		Covered under Hospital/Facility Services up to 60 days PCY Covered under Outpatient Services up to 60 visits PCY	

PCY = Per Calendar Year

* Deductible waived

** If you choose brand name drugs when generic equivalent is available, you will be responsible for the difference in cost between the brand name and the generic equivalent drugs.

*** Summary of out of network coverage is available on the Summary of Benefits and coverage (SBC). Please note that there is no out of network coverage for the HMO plan (except emergencies).

2018/2019 PLAN YEAR COSTS FOR MEDICAL COVERAGE

Monthly Cost* of Medical Coverage based on FTE

PPO Plan 2				
FTE	Employee (Ee) ONLY	Ee + Spouse/ Domestic Partner (DP)	Ee + Children (Ch)**	Ee + Family (Fam)**
1.0	326.64	638.40	511.08	909.14
.90-.99	373.78	674.74	551.84	936.08
.80-.89	459.46	747.50	629.88	997.66
.70-.79	545.18	824.98	710.70	1068.00
.60-.69	630.88	904.98	793.04	1143.04
.50-.59	716.58	986.50	876.24	1220.92
PPO Plan 3				
FTE	Ee ONLY	Ee + Spouse/DP	Ee + Ch**	Ee + Fam**
1.0	236.56	473.08	389.16	709.64
.90-.99	283.70	509.98	429.68	736.26
.80-.89	369.38	584.78	508.34	800.20
.70-.79	455.08	664.22	590.00	873.38
.60-.69	540.78	745.86	673.08	950.92
.50-.59	626.48	828.70	756.94	1030.90
PPO Plan 7				
FTE	Ee ONLY	Ee + Spouse/DP	Ee + Ch**	Ee + Fam**
1.0	158.60	317.16	249.24	468.22
.90-.99	191.34	343.20	278.12	487.80
.80-.89	248.26	393.24	331.12	531.32
.70-.79	305.18	446.18	385.76	580.48
.60-.69	354.92	493.58	434.16	625.64
.50-.59	404.64	541.62	482.90	672.06
High Deductible Health Plan (HDHP)				
FTE	Ee ONLY	Ee + Spouse/DP	Ee + Ch**	Ee + Fam**
1.0	96.70	165.80	145.08	283.26
.90-.99	128.58	195.14	175.18	308.32
.80-.89	183.90	248.32	229.00	357.86
.70-.79	239.20	302.54	283.54	410.20
.60-.69	287.32	350.08	331.24	456.72
.50-.59	335.46	397.78	379.08	503.74
HMO Plan (Core)				
FTE	Ee ONLY	Ee + Spouse/DP	Ee + Ch**	Ee + Fam**
1.0	180.94	414.26	371.72	711.18
.90-.99	220.00	442.80	402.16	726.34
.80-.89	289.72	501.84	463.16	771.84
.70-.79	359.40	565.50	527.90	827.80
.60-.69	425.52	627.88	590.98	885.48
.50-.59	491.62	691.38	654.94	945.60

*1/2 is taken each paycheck

** Includes your child(ren) or your domestic partner's child(ren) up to age 26