Church Pension Group Services Corporation

2020 HMO Renewals

Plan Design: Group Health Coop. - Diocese of Olympia M811 & M812

M811 2020 Plan Design

BASIC INFORMATION	
Carrier	Kaiser Foundation Health Plan of Washingtor
Plan Name	Kaiser Permanente
Plan Location	Seattle, WA
Plan Year	2020
BACKGROUND INFORMATION	
Member Services Telephone	1-888-901-4636
Member Services Hours Weekdays	8 AM to 5 PM Monday thru Friday
Member Services Hours Weekends	Not available
Self-referral to OB-GYN	Yes
Self-referral to Specialist	Yes
Default PCP assigned if none chosen?	No
Calendar year deductible	$200 individual/$400 family
Annual out-of-pocket maximum	$2,000 individual/$4,000 family
Lifetime maximum coverage per persor	Unlimited
Out of area dependent coverage	First Health Network/Out of Network Providers
Conversion privilege/policy at the end of The Medical Trust Extension Period	Conversion plans are available
Web Site Address	www.kp.org
Are participants required to file claims?	No
PRIMARY CARE	
Routine Office Visit	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Physician Home Visit	Covered in full
Specialty Care	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
PREVENTIVE CARE	
Annual physical exam	Covered in full
Pediatric Exams	Covered in full
Cancer Screenings	Covered in full
Cardiovascular Screenings	Covered in full
Pap Smears (annually)	Covered in full
Mammography	Covered in full
Immunizations: Adult	Covered in full
Immunizations: Child	Covered in full
Allergy tests and treatments	After deductible, member pays $15/$5 enhanced copayment and 20% plan coinsurance
OUTPATIENT CARE	
Second surgical opinion	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Lab	1st $500 of lab/xray covered in full, then deductible and coinsurance apply
X-Ray	1st $500 of lab/xray covered in full, then deductible and coinsurance apply
Outpatient surgery	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Physical Therapy	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Occupational Therapy	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Speech Therapy	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Chiropractic Services	Preferred Network: $15 copay; Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
HEARING CARE	
Audiometric exam	Not covered
Hearing evaluation test	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Hearing hardware (Hearing aid)	Not covered

VISION CARE	
Eye care referral required	No
Routine Eye Exams (includes refraction)	Covered in full
Exam for the treatment of disease or injury to the eye	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Regular lenses and frames	Not covered
Contact lenses	Not covered
Cataract surgery	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
PRESCRIPTION DRUG	
Annual Rx deductible	None
Annual Rx maximum	None
Retail: Generic	$10 copay per 30 day supply
Retail: Formulary Brand	$35 copay per 30 day supply
Retail: Non-formulary Brand	$70 copay per 30 day supply
Oral Chemotherapy Medications	Preferred generic $10 copay/preferred brand $35 copay/non-preferred $70 copay up to a 30 day supply
Mail Order: Generic	$20 copay per 90 day supply
Mail Order: Formulary Brand	$70 copay per 90 day supply
Mail Order: Non-formulary Brand	$140 copay per 90 day supply
Mandatory formulary list	Yes
Number of drugs on formulary	2500
Generic Requirement	No
Oral Contraceptives	Covered in full
Diaphragms	Covered in full
Fertility drugs	Not covered
Viagra	Not covered
FAMILY PLANNING/MATERNITY CARE	
Physician's office: Pre/Post-natal	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply/Preventive: Covered in full
In hospital: Physician's services	Deductible and coinsurance apply
Newborn nursery services	Deductible and coinsurance apply
Infertility services	Not covered
In vitro fertilization	Not covered
Artificial insemination	Not covered
Female tubal	Covered in full
Male vasectomy	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Elective abortion	Covered in full
Birthing centers, licensed and certified	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Maternity coverage for unmarried female dependents	Yes
Automatic coverage from birth for baby if parent is enrolled at baby's birth	Yes
Midwives, licensed and certified	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply/Preventive: Covered in full
INPATIENT CARE	
Hospital copay	Deductible and coinsurance apply
Semi-private care	Deductible and coinsurance apply
Private care	Deductible and coinsurance apply
Intensive care	Deductible and coinsurance apply
Lab and X-Ray	Deductible and coinsurance apply
Surgery	Deductible and coinsurance apply
Affiliated Hospitals	Deductible and coinsurance apply
Non-participating Hospitals	Deductible and coinsurance apply-Pre-authorization required
Physician/Surgeon services	Deductible and coinsurance apply
Surgical assistance	Deductible and coinsurance apply
Ancillary services	Deductible and coinsurance apply
Consultations	Deductible and coinsurance apply
Special duty nursing	Deductible and coinsurance apply
Physical therapy	Deductible and coinsurance apply-30 days per calendar year
Renal Dialysis	Deductible and coinsurance apply

Anesthesia	Deductible and coinsurance apply
Blood transfusion (if not replaced)	Deductible and coinsurance apply
Pulmonary Tuberculosis	Deductible and coinsurance apply

TRANSPLANTS	
Heart	Deductible and coinsurance apply
Kidney	Deductible and coinsurance apply
Liver	Deductible and coinsurance apply
Lung	Deductible and coinsurance apply
Cornea	Deductible and coinsurance apply
Bone marrow	Deductible and coinsurance apply
Other	Deductible and coinsurance apply
EMERGENCY CARE	
In-Area (when followed by admission)	Deductible and coinsurance apply
In-Area (when not followed by admission)	$75 copay, deductible and coinsurance apply
Out-of-Area (when followed by admission)	Deductible and coinsurance apply-Pre-authorization required
Out-of-Area (when not followed by admission)	$75 copay, deductible and coinsurance apply
Urgent care Clinic visit	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Ambulance	Deductible and coinsurance apply
MENTAL HEALTH CARE	
Combined with substance abuse	No
Outpatient- Coverage level/Visits	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Inpatient- Coverage level/Visits	Deductible and coinsurance apply
SUBSTANCE ABUSE CARE	
Detox Outpatient- Coverage level/Visits	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply
Detox Inpatient- Coverage level/Visits	Deductible and coinsurance apply
Rehab Outpatient- Coverage level/Visits	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply-45 visits per calendar year
Rehab Inpatient- Coverage level/Visits	Deductible and coinsurance apply-30 days per calendar year
TMJ CARE	
Surgery	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply; Inpatient-Deductible and coinsurance apply
Appliances	Deductible and coinsurance apply
Therapy	Deductible and coinsurance apply
DENTAL CARE	
Implants	Not covered
Accidental Injury to Teeth	Not covered
Surgical Removal of Tumors, Cysts, & Impacted Teeth	Preferred Network: $15 copay/$5 enhanced (using Kaiser facilities); Non-Preferred Network: 0 Copay, Deductible & Coinsurance apply; Inpatient-Deductible and coinsurance apply
OTHER CARE	
Noncustodial home health care	Covered in full
Hospice care	Covered in full
Prescribed care in a Noncustodial skilled nursing facility	Up to 60 days per calendar year; deductible and coinsurance apply
Acupuncture	Covered up to 8 visits per calendar year without prior authorization; $15 copay, deductible and coinsurance apply
Durable Medical Equipment	Deductible and coinsurance apply