2018 Kaiser Sr. Advantage HMO - California - Post 65 (Medicare Eligible)*

Medicare Eligible / Post-65 Only	Kaiser Permanente Senior Advantage HMO - Northern & Southern California**
Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.	
Plan changes are in orange.	**2018 In-Network**
General Information	
Lifetime Maximum Benefit	None
Annual Maximum Benefit	None
Coinsurance Percentage	100% covered after applicable copay (80% covered for DME and P&O)
Precertification Requirements	None
Precertification Penalty	None
Health Savings Account (HSA)	N/A
Health Reimbursement Account (HRA)	N/A
R & C	N/A
Deductibles	
Individual Annual Deductible	None
Family Annual Deductible	None
Applies to Out-of-Pocket Maximum	N/A
Prescription benefits are covered under medical deductible	N/A
Out-of-Pocket Mx per Plan Year	
Individual Out-of-Pocket Maximum Per Year	$1,500.00
Family Out-of-Pocket Maximum Per Year	$3,000.00
Outpatient Services	
Primary Care Physician Visits	$15 per visit
Specialist Visit	$15 per visit
Lab tests and X-ray	No charge. $15 office visit copay may apply.
Specialized Imaging	No charge
Outpatient Surgery	$15 per procedure
Allergy Testing	$15 per visit
Allergy Injections	$3 per visit
Preventive Care	
Well Child Care Office Visit	100% covered
Well Child Age limit	23 months
Adult Routine Physical Exams	100% covered
Adult Immunizations	No charge for immunizations; office visit copay may apply
Routine Mammogram	No charge
Pap Smear	100% covered
Prostate Screening (PSA)	100% covered
Colon Cancer Screenings	100% covered
Cardiovascular screenings	100% covered
Hearing Evaluations	Preventive: 100% covered; Diagnostic: $15 copay
Inpatient Hospital	
Deductible per Confinement	None
Deductible per Day	None
Hospital Services	$200 per admission
Physicians and Surgeons' Services	Included in $200 per admission inpatient copay
Emergency Services	
Emergency Room Treatment	$50 per visit** **Does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition
Non-emergency or non-urgent use of ER	$50 per visit; Non-emergency or non-urgent use of ER is not covered
Ambulance	$50 per trip, when determined to meet the criteria that define an emergency
Urgent Care Facility Services	$15 per visit
Physician Office Visit	Included in $50 ER copay
After Hours	$15 per Urgent Care visit; $50 per ER visit
Maternity Care	
Physician Office Visit	No charge
Maternity Care - Inpatient Delivery	$200 per admission
Midwife delivery services	Included in $200 inpatient admission copay; at facilities where available
Mental Health	
Deductible per Confinement	None
Deductible per Day	None
Mental Health Inpatient	$200 per admission
Mental Health-Inpatient Plan Maximums	None
Mental Health Outpatient	$15 per individual visit
Mental Health - Group Therapy	$7 per group visit
Mental Health-Outpatient Plan Maximums	Unlimited
Severe Mental Illness	$200 per admission for inpatient; $15 per individual outpatient visit; $7 per group outpatient visit; no day or visit limits.

**based on zip code availability

2018 Kaiser Sr. Advantage HMO - California - Post 65 (Medicare Eligible)*

Medicare Eligible / Post-65 Only	Kaiser Permanente Senior Advantage HMO - Northern & Southern California**
Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.	
Plan changes are in orange.	**2018 In-Network**
Substance Abuse	
Deductible per Confinement	None
Deductible per Day	None
Detoxification	$200 per admission
Substance Abuse - Inpatient Treatment	$100 per admission to Transitional Residential Recovery Services (TRRS) in a non-medical setting
Substance Abuse-Inpatient Plan Maximums	No day limits, in compliance with MHPA
Substance Abuse-Outpatient	$15 per individual visit; $5 per group visit
Substance Abuse-Outpatient Plan Maximums	Unlimited
Rehabilitation Therapy	
Inpatient Rehabilitation	Included in $200 per admission inpatient copay
Outpatient Physical, Occupational, and Speech Therapy	$15 copay per visit. Benefits are limited to medically necessary therapy authorized by a Plan physician.
Alternative Care	
Chiropractic Care	$15 per visit***** *****$15 per visit for manual manipulation of the spine only; $15 per visit, up to 30 visits per calendar year with American Specialty Health Plans chiropractic rider
Acupuncture	$15 per visit when approved by a Plan physician, generally as a component of a multidisciplinary pain management program for the treatment of chronic pain
Acupressure	Not covered
Massage Therapy	Not covered
Other Services	
Private-Duty Nursing Care	Not covered, except when deemed medically necessary by a Plan physician for inpatient care
Durable Medical Equipment	20% coinsurance when prescribed by a Plan physician in accordance with Medicare and Formulary guidelines
Prosthetic and Orthotic Appliances	20% coinsurance when prescribed by a Plan physician in accordance with Formulary guidelines
Smoking Cessation	Covered health education classes are at no charge. Smoking cessation drugs are covered the same as other drugs when members participate in a behavioral health class.
Weight control program	Covered health education classes are at no charge
Bariatric surgery	If determined medically necessary by a Plan physician, and program requirements are met, covered at $15 per visit, $200 per admission for inpatient hospitalization
TMJ	Inpatient: $200 copay per admission; Outpatient: $15 copay per encounter. Must be deemed medically necessary. (i.e., etiology must be medical not dental)
Podiatry Services	$15 per visit when medically necessary
Home Health Care	No charge when prescribed by a Plan physician for part-time intermittent care
Skilled Nursing Facility Care	No charge, up to 100 days per benefit period
Hospice Care	No charge for Members without Medicare Part A (see Evidence of Coverage for details for Members with Medicare Part A)
Hearing Aids	Not covered
Family Planning	
Tubal ligation	$15 per outpatient procedure; $200 per admission for inpatient surgery after appropriate counseling.
Vasectomy	$15 per outpatient procedure; $200 per admission for inpatient surgery after appropriate counseling.
Contraceptive Drugs	Covered under outpatient prescription benefit
Contraceptive Devices	$20 copay for diaphragm or cervical cap; no charge for IUD
Infertility Testing	$15 per visit; no charge for lab
Infertility Treatments - Office Visit	$15 per visit
Infertility Treatments - Surgery	$15 per outpatient procedure; $200 per admission for inpatient surgery
In Vitro Fertilization	Not covered
Infertility Treatments - Lifetime Maximum	Treatment for involuntary infertility is covered as authorized by a Plan physician

**based on zip code availability

2018 Kaiser Sr. Advantage HMO - California - Post 65 (Medicare Eligible)*

Medicare Eligible / Post-65 Only	Kaiser Permanente Senior Advantage HMO - Northern & Southern California**
Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.	
Plan changes are in orange.	**2018 In-Network**
Vision Care	
Eye Examination	Preventive: 100% covered; Diagnostic: $15 copay
Lenses	$150 eyewear allowance every 24 months for frames and lenses OR elective contact lenses
Frames	$150 eyewear allowance every 24 months for frames and lenses OR elective contact lenses
Contact lenses- necessary	When prescribed by a Plan physician, no charge for contact lenses to treat aniridia (missing iris), up to two lenses per eye every 12 months. When prescribed by a Plan physician for aphakia (absence of the crystalline lens of the eye), no charge for up to 6 lenses per eye every 12 months, through age 9
Contact lenses-elective	$150 eyewear allowance every 24 months for frames and lenses OR elective contact lenses
Lasik Eye Surgery	Not covered
Organ and Tissue Transplants	
Organ Transplant -Inpatient	$200 per admission
Organs covered	Heart, lung, heart/lung, liver, kidney, small bowel, pancreas, simultaneous pancreas/kidney and liver/kidney, cornea, and bone marrow, when transplant is determined to be medically necessary
Transplant Travel	Covered when pre-authorized by the Plan physician and related to the provision of covered services, in accordance with Plan policies
Transplant donor expenses	Certain medical and hospital expenses are covered if approved by Health Plan and the expenses are directly related to the transplant
Lifetime Maximum	None
Prescription Drug Coverage	
Annual Prescription Deductible - Family	None
Annual Prescription Deductible - Individual	None
Out-of-Pocket Maximums - Individual	N/A
Out-of-Pocket Maximums - Family	N/A
Annual Maximum Benefit	Unlimited
Lifetime Maximum Benefit	Unlimited
Generic Substitution	Determined by patient's Plan physician
Retail Refill Penalty	None
Prescription Drug Retail	
Retail - Generic	$10 per prescirption, up to a 30-day supply All prescriptions must be medically necessary, prescribed by a Plan physician, and obtained from a Plan pharmacy of from Plan mail order to be covered
Retail - Brand Formulary	$20 per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies
Retail - Brand Non-Formulary	$20 per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies
Single Source Brand	$20 per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies
Multi Source Brand	$20 per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies
Injectable Medications	$10 (generic)/$20 (brand) per prescription, up to 30-day supply; must be medically necessary, prescribed by a Plan physician, and filled through Plan pharmacies

**based on zip code availability

2018 Kaiser Sr. Advantage HMO - California - Post 65 (Medicare Eligible)*

Medicare Eligible / Post-65 Only	Kaiser Permanente Senior Advantage HMO - Northern & Southern California**
Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.	
Plan changes are in orange.	**2018 In-Network**
Prescription Drug Mail Order	
Mail-Order - Generic	$10 for up to a 30-day supply, or $20 for a 31 to 100-day supply
Mail-Order - Brand Formulary	$20 for up to 30-day supply, or $40 for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order
Mail-Order - Brand Non-Formulary	$20 for up to 30-day supply, or $40 for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order
Single Source Brand	$20 for up to 30-day supply, or $40 for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order
Multi Source Brand	$20 for up to 30-day supply, or $40 for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order
Injectable Medications	$10 (generic)/$20 (brand) per prescription for up to 30-day supply, or $20 (generic)/$40 (brand) per prescription for a 31- to 100-day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order
Day Supply	Up to 100
Other Services - Prescription Drugs	
Over the Counter	Not covered
Prenatal Vitamins	Not covered
Diabetic Supplies	Insulin: $20 copay for up to 100-day supply; Testing supplies: 80% covered up to 100-day supply in accordance with DME Medicare and formulary guidelines
Lifestyle Drugs	Drugs for the treatment of impotency are 75% covered with a maximum dosage limit of 27 doses for 100-day supply.
Contraceptives - Injectable	Covered at no charge when dispensed in Plan Medical Offices
Fertility Drugs	Covered at applicable prescription copay
Smoking Cessation	Covered at applicable prescription copay if prescribed by a Plan physician and patient is concurrently participating in a Plan-approved behavioral modification program
Cosmetic Medications	Not covered
Nutritional Supplements	Not covered

**based on zip code availability