2022 Boeing plans

FEATURES	HMO	VIRTUAL PLUS
Annual medical deductible (individual/family)	None	$250/$500
Annual out-of-pocket maximum (individual/family)	$7,350/$14,700	$2,000/$4,000
Coinsurance	None	10%
BENEFITS		
Office Visits Primary Care	$30	$10* In-person authorized Deductible and coinsurance apply when self-directed
Office Visits Specialty Care	$40	$30* In-person authorized Deductible and coinsurance apply when self-directed
Hospital Inpatient	$300 per admit	10% Coinsurance after deductible
Outpatient Surgery	$40	10% Coinsurance after deductible
RX Retail (30 day)	$10/$35/$50 Preferred generic/preferred brand/ non-preferred generic and brand	$10/$30/$150 Preferred generic, preferred brand, preferred specialty
RX Mail-Order (90 day)	$25/$85/$125	$5/$60 (after 1st fill maintenance drugs must be mail order)
Acupuncture	$30 8 visits no prior approval, additional with approval	$10 – 12 visits per calendar year
Ambulance	100% covered	20% Coinsurance
Bariatric	$300 per admit	10% Coinsurance after deductible
DME	100% covered	20% Coinsurance
Lab & X-ray	100% covered	10% Coinsurance after deductible
ER	$100 Copay	$200 Copay, 10% Coinsurance after deductible
Hearing Hardware	$800 per ear per 36 months	$800 per ear per 36 months
Chiropractic	$40 – 15 visits per calendar year	$10 – 10 visits per calendar year
Rehabilitation Therapy (PT/OT/ST, massage)	$40 – No visit limit	$30 45 visit limit, combined all therapies (Mental Health diagnosis no limit)
Vision Hardware	$140 per pair, 2 pair max per 24 months	$140 per pair, 2 pair max per 24 months
Maternity Inpatient	$300 per admit	10% Coinsurance after deductible
Maternity Outpatient Visits	$30, routine care not subject to copay	$10, routine care not subject to copay
Wigs	Not covered	Not covered
Infertility	**IVF/GIFT/ZIFT includes cryopreservation:** 50% to $30,000 lifetime max **Infertility drugs**: 50% no lifetime maximum	**IVF/GIFT/ZIFT includes cryopreservation:** 50% to $30,000 lifetime max **Infertility drugs**: 50% no lifetime maximum

*All Services delivered via telehealth and 1st non-preventive prmary care office visit are covered in full. Deductible and Coinsurance do not appy to authorized outpatient visits in the clinic but do apply to all non-authorized outpatient services, including all surgical services. All other services covered at applicable cost shares.

KAISER PERMANENTE®

Primary Care

These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic • Emergency Medicine (where ER copay doesn't apply) • Family Planning • Family Practice • General Practice • Gerontology/Geriatrics • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics & Gynecology • Optometry • Osteopathy • Pediatrics • Pharmacist • Urgent Care • Women's Health Care (nonpreventive)

Specialty Care

These types of care are considered specialty care:

Allergy & Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardio-vascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Hematology/Oncology • Nutrition (nonpreventive) • Occupational Medicine • Occupational Therapy • Oncology Pharmacist • Ophthalmology • Orthopedics • ENT/Otolaryngology • Pain Management • Pathology • Physiatry (Physical Medicine) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (Nuclear Medicine, Radiation Therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all specific surgeries) • Urology

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.