2019 Medical Plans Overview for full-time California

The summary below highlights some of the features of the medical plan(s). For comprehensive details about the medical plans, see the Apple Benefits Book.

Plan Name	Apple Saver PPO		Apple Plus PPO		Kaiser
Network Type	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**
Overview	The Apple Saver PPO (with HSA) is a high deductible health plan that allows you to receive Apple's contribution towards the Optum Bank Health Savings Account (HSA). You can choose between the Apple Saver PPO (with HSA) or (no HSA). If you use a UnitedHealthcare (UHC) network provider or Harvard Pilgrim providers if you live in MA, ME or NH, preventive care is covered 100%. Coverage for non-preventive care is provided after you satisfy the deductible. You may receive care from any provider; however, benefits from a non-PPO provider are only payable at 70% of Eligible Expenses. Utilizing a doctor from the PPO network will ensure a higher payment and will save you and Apple money. To ensure treatment meets UHC's clinical guidelines for coverage, you may be required to obtain Prior Authorization for complex health services, such as for any surgery, hospitalization, clinical trials and etc.. All of the coverage percentages noted below are based on UHC's definition of Eligible Expenses. Eligible Expenses for PPO providers are based on negotiated rates, while non PPO providers are based on various data resources.		When you use a doctor in the UnitedHealthcare Preferred Provider Organization (PPO) network (or Harvard Pilgrim providers if you live in MA, ME or NH) for office visits, the Apple Plus PPO Plan pays 100% for eligible charges after a $20 copayment. Specialist visits (chiropractor, physical therapist, dermatologist, cardiologist, etc.) require a $30 copayment. You may receive care from any provider, however, benefits from a non-PPO provider are only payable at 70% of Eligible Expenses. Utilizing a doctor from the PPO network will ensure a higher payment and will save you and Apple money. To ensure treatment meets UHC's clinical guidelines for coverage, you may be required to obtain Prior Authorization for complex health services, such as for any surgery, hospitalization, clinical trials and etc.. All of the coverage percentages noted below are based on UHC's definition of Eligible Expenses. Eligible Expenses for PPO providers are based on negotiated rates, while non PPO providers are based on various data resources.		**Northern California Residents**: All services must be provided by Kaiser Northern California providers at Kaiser facilities, except in certain emergency situations. **Southern California Residents**: All services must be provided by Kaiser Southern California providers at Kaiser facilities, except in certain emergency situations.
How the Plan Works					
Apple HSA Contribution	$750 employee only coverage, per calendar year (prorated $187.50 per quarter) $1,500 for employee and dependent(s) coverage, per calendar year (prorated $375 per quarter)		Not applicable		Not applicable
Plan Year Deductible	$1,500 Employee only $3,000 Employee + dependent(s) (when dependent(s) are covered, the entire $3,000 amount must be satisfied) Combined medical and prescription deductible for in- and out-of-network services		$300 each individual up to a maximum of $900 Family Separate deductibles for in- and out-of-network services will cross apply	$600 each individual up to a maximum of $1,800 Family Separate deductibles for in- and out-of-network services will cross apply	No deductible
Copay	Copays apply to preventive medications only		Office visit and prescription copays vary based on type of provider and prescription	Copays not applicable for out-of-network providers, except for prescriptions	$20 copay (Plan pays 100% for most eligible charges after you pay copay, if applicable)
Coinsurance	Plan pays 90% after deductible, except where noted below	Plan pays 70% after deductible, except where noted below	Plan pays 90% after deductible, except where noted below	Plan pays 70% after deductible, except where noted below	Not applicable, except where noted below
Annual Out-of-Pocket Maximum	$2,000 per individual $4,000 combined maximum when covering dependent(s) (when dependent(s) are covered, the entire $4,000 amount must be satisfied) Separate maximums for in- and out-of-network services will cross apply Once your portion of medical and prescription costs reaches the Annual Out-of-Pocket Maximum, the plan pays 100% of eligible expenses.	$4,000 per individual $8,000 combined maximum when covering dependent(s) (when dependent(s) are covered, the individual out-of-network maximum amount is $6,850 which applies towards the $8,000 out-of-network annual family amount) Separate maximums for in- and out-of-network services will cross apply Once your portion of medical and prescription costs reaches the Annual Out-of-Pocket Maximum, the plan pays 100% of eligible expenses.	$2,000 per individual $4,000 when covering dependent(s) Separate maximums for in- and out-of-network services will cross apply Once your portion of medical and prescription costs reaches the Annual Out-of-Pocket Maximum, the plan pays 100% of eligible expenses.	$4,000 per individual $8,000 combined maximum when covering dependent(s) Separate maximums for in- and out-of-network services will cross apply Once your portion of medical and prescription costs reaches the Annual Out-of-Pocket Maximum, the plan pays 100% of eligible expenses.	$1,500 per individual $3,000 combine maximum when covering dependent(s) Once your portion of costs reaches the Annual Out-of-Pocket Maximum, the plan pays 100% of eligible expenses, with the exception of prescription copays.
Preventive Care					
Well Baby/Child Care Visit Immunizations Routine Physical Exam Routine Gynecological Exam Routine Mammography	100% (no deductible)	70% (no deductible)	100% (no deductible)	70% (no deductible)	100%
Doctors and Other Providers					
Doctor's Office Visit	90% after deductible UCH Virtual Visits: 90% after deductible	70% after deductible UHC Virtual Visits: Not covered	$20 copay UHC Virtual Visits: $10 copay	70% after deductible UHC Virtual Visits: Not covered	$20 copay
Specialist Office Visit	90% after deductible	70% after deductible	$30 copay	70% after deductible	$30 copay

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Non-hospital X-ray and Lab Services	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100%
Therapies: Physical, Occupational, Speech Therapy (Restorative Only)	90% after deductible Includes services related to developmental delays	70% after deductible Includes services related to developmental delays	$30 copay (billed with an office visit) Includes services related to developmental delays	70% after deductible Includes services related to developmental delays	$20 copay Speech Therapy (not for educational or learning disabilities)
Chiropractic Services / Spinal Manipulation	90% after deductible	70% after deductible	$30 copay (billed with an office visit)	70% after deductible	$25 copay Chiropractic for Kaiser members provided by American Speciality Health Insurance (ASHI)
Acupuncture	90% after deductible	70% after deductible	$30 copay (billed with an office visit)	70% after deductible	$25 copay Acupuncture for Kaiser members provided by American Speciality Health Insurance (ASHI)
Emergency Care					
Hospital Emergency	90% after deductible		90% after deductible		100% after $75 copay (per occurrence and copay waived if admitted to hospital)
Non Emergency	50% after deductible	50% after deductible	50% after deductible	50% after deductible	Not covered
Ambulance (for medically necessary services)	90% after deductible		90% after deductible		100% after $50 copay
Hospital					
Inpatient Hospitalization - room & board and other charges related to a	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after $200 copay (per admission)
Outpatient Hospitalization	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% $30 copay (per outpatient surgical procedure)
Diagnostic Lab & X-ray while Hospitalized	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100%
Other Medical Care					
Allergy Treatment	90% after deductible	70% after deductible	$30 copay, then 100% (billed with an office visit) Allergy testing and/or injections billed without an office visit 90% after deductible	70% after deductible	$30 copay for testing and injection (billed with an office visit) $3 copay for injection only
Durable Medical Equipment	90% after deductible	70% after deductible	90% after deductible	70% after deductible	90%
Infertility Coverage	Coverage may include Assisted Reproductive Technology (ART) and coverage for in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); embryo transport; donor ovum and semen and related costs, including collection, preparation and storage of; artificial insemination and cryopreservation; and related prescription drugs. Combined medical and prescription lifetime maximum for in- and out-of-network services.		Coverage may include Assisted Reproductive Technology (ART) and coverage for in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); embryo transport; donor ovum and semen and related costs, including collection, preparation and storage of; artificial insemination and cryopreservation; and related prescription drugs. Combined medical and prescription lifetime maximum for in- and out-of-network services.		Covers diagnosis and treatment of an underlying medical condition that causes infertility and may include Assisted Reproductive Technology (ART) and coverage for in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); embryo transport; donor ovum and semen and related costs, including collection, preparation and storage of; artificial insemination and cryopreservation; and related prescription drugs. Coverage is limited to a lifetime maximum of a single treatment cycle for one of the ART procedures
Infertility Treatment	90% after deductible Up to a $20,000 lifetime maximum	70% after deductible Up to a $20,000 lifetime maximum	$30 copay (billed with an office visit) All other services outside an office visit: 90% after deductible Up to a $20,000 lifetime maximum	70% after deductible Up to a $20,000 lifetime maximum	$30 copay
Hospice	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100%
Skilled Nursing	90% after deductible	70% after deductible	90% after deductible	70% after deductible	100% up to 100 consecutive days per plan year
Mental Health / Chemical Dependency					
Doctor's Office Visit	90% after deductible Telemedicine visit: 90% after deductible	70% after deductible Telemedicine visit: Not covered	Office visit: $20 copay Telemedicine visit: $10 copay	Office visit: 70% after deductible Telemedicine visit: Not covered	$20 copay
All other outpatient / inpatient services	90% after deductible	70% after deductible	90% after deductible	70% after deductible	Outpatient: $20 copay Inpatient: $200 copay (per outpatient procedure or admission)
Prescription Drugs					

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At the Pharmacy	**Preventive drugs -** you pay the lower of 10% or the applicable copay: Tier 1 (lowest-cost drug) $10 copay Tier 2 (mid-range cost drug) $30 copay Tier 3 (highest-cost drug) $50 copay (up to the required dosage for 30-days) **Non-Preventive drugs**: 90% after deductible 90-day fills available at 3x the applicable cost		Tier 1 (lowest-cost drug) $10 copay Tier 2 (mid-range cost drug) $30 copay Tier 3 (highest-cost drug) $50 copay (up to the required dosage for 30-days) 90-day fills available for 3x copay		Generic: $10 copay Formulary Brand: $30 copay Non-Formulary Brand: Not covered. $30 copay when medically necessary and prescribed as by a plan physician (up to the required dosage for 30 days)
Speciality Pharmacy drugs at Pharmacy or Mail order	10% up to the applicable copays for preventive drugs (up to a 30-day supply)	Not applicable	Subject to above Tier level copays (up to a 30-day supply)	Not applicable	Not applicable
Mail order	**Preventive drugs**: 2x pharmacy costs (up to the required dosage for 90-days) **Non-Preventive drugs**: 90% after deductible	Not applicable	2x pharmacy copays (up to a 90-day supply)	Not applicable	2x pharmacy copays (up to the required dosage for 100 days)
Employee Assistance Program					
ComPsych: EAP	You and your family members can get up to 8 free sessions, per counseling topic, in a 12-month period. You can also get unlimited telephonic assistance for financial guidance and legal consultations, along with guidance and referrals for elder care, parenting, childcare and even pet care needs. Assistance available 24 hours a day, seven days a week. US: 844-862-0889 International: +1 312-595-0074		You and your family members can get up to 8 free sessions, per counseling topic, in a 12-month period. You can also get unlimited telephonic assistance for financial guidance and legal consultations, along with guidance and referrals for elder care, parenting, childcare and even pet care needs. Assistance available 24 hours a day, seven days a week. US: 844-862-0889 International: +1 312-595-0074		You and your family members can get up to 8 free sessions, per counseling topic, in a 12-month period. You can also get unlimited telephonic assistance for financial guidance and legal consultations, along with guidance and referrals for elder care, parenting, childcare and even pet care needs. Assistance available 24 hours a day, seven days a week. US: 844-862-0889 International: +1 312-595-0074
Before-Tax Cost					
Employee	Per Pay Period: $24.28 Per Month: $52.61 Per Year: $631.28		Per Pay Period: $42.74 Per Month: $92.60 Per Year: $1,111.24		Per Pay Period: $25.38 Per Month: $54.99 Per Year: $659.88
Employee + Spouse or Domestic Partner	Per Pay Period: $95.87 Per Month: $207.12 Per Year: $2,492.62		Per Pay Period: $138.08 Per Month: $299.18 Per Year: $3,590.08		Per Pay Period: $114.68 Per Month: $248.48 Per Year: $2,981.68
Employee + Child(ren)	Per Pay Period: $64.01 Per Month: $138.69 Per Year: $1,664.26		Per Pay Period: $99.91 Per Month: $216.48 Per Year: $2,597.66		Per Pay Period: $83.66 Per Month: $181.27 Per Year: $2,175.16
Employee + Family	Per Pay Period: $118.26 Per Month: $256.23 Per Year: $3,074.76		Per Pay Period: $185.98 Per Month: $402.96 Per Year: $4,835.48		Per Pay Period: $164.41 Per Month: $356.23 Per Year: $4,274.66

The Medical Plan(s) Chart highlights commonly used services and generally indicates how you and a medical plan will cover medical expenses you and/or your enrolled dependents incur. Benefits are provided for covered services that are medically necessary unless otherwise indicated. Some services are subject to annual or lifetime limits. This chart does not reflect all covered services, plan exclusions, limitations, or restrictions. It is not a contract or guarantee of coverage. See the Apple Benefits Book or, for insured coverage, the applicable Evidence of Coverage (available on HRWeb) for more information.