Benefit Summary

# PLU Active Plan HSA IND & FAM
# Group Number: 1658400/1658500

KAISER PERMANENTE®

| **Effective Date** 1/1/2027 | **Health Plan** Core HMO | **Ref** RQ-217488 |
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This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

| **Benefits** | **Inside Network** |
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| **Plan deductible** | Individual deductible: $1,750 per calendar year<br>Family deductible: $3,500 per calendar year<br><br>Until the total family annual deductible is met, benefits will not be provided for any family member |
| **Individual deductible carryover** | 4th quarter carryover does not apply |
| **Plan coinsurance** | Plan pays 80%, you pay 20% |
| **Out-of-pocket limit** | Individual out-of-pocket limit: $3,500<br>Family out-of-pocket limit: $7,000<br><br>Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:<br><br>All cost shares for covered services<br><br>If enrolled on the family plan you must meet the family out-of-pocket maximum |
| **Pre-existing condition** (PEC) **waiting period** | No PEC |
| **Lifetime maximum** | Unlimited |
| **Outpatient services** (Office visits) | No copay, deductible and coinsurance apply |
| **Hospital services** | **Inpatient services:** Deductible and coinsurance apply<br>**Outpatient surgery:** No copay, deductible and coinsurance apply |
| **Prescription drugs** (some injectable drugs may be covered under Outpatient services) | Preferred generic/preferred brand<br>$15/$30 copay, deductible applies up to a 30 days supply |
| **Prescription mail order** | 3 x prescription cost share per 90 day supply |
| **Acupuncture** | Covered up to 12 visits per calendar year<br>No copay, deductible and coinsurance apply |
| **Ambulance services** | Deductible and coinsurance |
| **Chemical dependency** | **Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** No copay, deductible and coinsurance apply |

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| **Devices, equipment and supplies**<br>• Durable medical equipment<br>• Orthopedic appliances<br>• Post-mastectomy bras limited to two (2) every six (6) months<br>• Ostomy supplies<br>• Prosthetic devices | Covered at 50%, deductible applies |
| **Diabetic supplies** | Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits. |
| **Diagnostic lab and X-ray services** | **Inpatient:** Covered under Hospital services<br>**Outpatient:** Deductible and coinsurance apply<br><br>High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services. |
| **Emergency services** (copay waived if admitted) | $0 copay<br>Deductible and coinsurance apply |
| **Hearing exams** (routine) | No copay, deductible and coinsurance apply |
| **Hearing hardware** | 1 aid per ear every 36 months; 50% Coinsurance, Deductible applies |
| **Home health services** | No visit limit, deductible and coinsurance apply |
| **Hospice services** | Deductible and coinsurance apply |
| **Infertility services** | Not covered |
| **Manipulative therapy** | Covered up to 10 visits per calendar year without prior authorization<br>No copay, deductible and coinsurance apply |
| **Massage services** | See Rehabilitation services |
| **Maternity services** | **Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** No copay, deductible and coinsurance apply |
| **Mental Health** | **Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** No copay, deductible and coinsurance apply |
| **Naturopathy** | Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan<br>No copay, deductible and coinsurance apply |
| **Newborn Services** | Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother. |
| **Obesity-related surgery (bariatric)** | Covered at cost shares when medical criteria is met |
| **Organ transplants** | Unlimited, no waiting period<br><br>**Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** No copay, deductible and coinsurance apply |
| **Preventive care**<br>Well-care physicals, immunizations, Pap smear exams, mammograms | Covered in full<br><br>Women's contraception is covered as preventive, and Men's contraception is covered in full after annual deductible has been satisfied |
| **Rehabilitation services**<br><br>Rehabilitation visits are a total of combined therapy visits per calendar year | **Inpatient:** 60 days per calendar year. Services with mental health diagnoses are covered with no limit.<br>Deductible and coinsurance apply<br>**Outpatient:** 60 visits per calendar year. Services with mental health diagnoses are covered with no limit.<br>No copay, deductible and coinsurance apply |
| **Skilled nursing facility** | Up to 60 days per calendar year, deductible and coinsurance apply |
| **Sterilization** (vasectomy, tubal ligation) | Women's sterilization is covered as preventive, and Men's sterilization is covered in full after the annual deductible has been satisfied. |
| **Temporomandibular Joint** (TMJ) **services** | **Inpatient:** Deductible and coinsurance apply<br>**Outpatient:** No copay, deductible and coinsurance apply |
| **Tobacco cessation counseling** | Quit for Life Program - covered in full |

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| **Routine vision care**<br>(1 visit every 12 months) | No copay, deductible and coinsurance waived |
| **Optical hardware**<br>Lenses, including contact lenses and frames | **Members under 19:** 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance<br>**Members age 19 and over:** $250 per 12 months<br><br>Not subject to deductible and coinsurance |
| **Virtual Care**<br>Including Telemedicine, Telephone Services and Online (E-Visits) | Deductible applies |

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All plans offered and underwritten by Kaiser Foundation Health Plan of Washington