Benefit Summary
Olympic Benefit Trust

KAISER PERMANENTE®

Effective Date 1/1/2025 | **Health Plan** Access PPO | **Ref** QR-110947

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	Preferred Provider Network	Out-of-Network
Plan deductible	Individual deductible: $2,500 per calendar year Family deductible: $5,000 per calendar year Until the total family annual deductible is met, benefits will not be provided for any family member	Individual deductible: $5,000 per calendar year Family deductible: $10,000 per calendar year 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	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 50%, you pay 50% of the Allowed Amount.
Out-of-pocket limit	Individual out-of-pocket limit: $7,000 Family out-of-pocket limit: $8,500 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services If enrolled on the family plan you must meet the family out-of-pocket maximum	Individual out-of-pocket limit: No limit Family out-of-pocket limit: No limit Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services If enrolled on the family plan you must meet the family out-of-pocket maximum
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	No copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** No copay, deductible and coinsurance apply	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** No copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $10/$35/$70 ($10/$30/$65 enhanced) copay up to a 30 day supply; Deductible applies. Certain preventive medications are covered in full (at a PPN pharmacy, 1st fill only, then covered at the PPN cost shares)	Preferred generic/preferred brand/non-preferred Not covered
Prescription mail order	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
Acupuncture	Covered up to 12 visits per calendar year No copay, deductible and coinsurance apply	Visit limits shared with preferred provider network
Ambulance services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply

Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Deductible and coinsurance apply	Deductible and coinsurance apply
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.	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 **Outpatient:** Deductible and coinsurance apply 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.	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply 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 Deductible and coinsurance apply	$0 copay Preferred provider deductible and coinsurance apply
Hearing exams (routine)	No copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
Hearing hardware	$3,000 per ear every 36 months, deductible applies	Benefit shared with preferred provider network
Home health services	Covered at deductible and coinsurance up to 130 visits total per calendar year	Visit limit shared with preferred provider network Deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 12 visits per calendar year without prior authorization; additional visits when approved by the plan No copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	No copay, deductible and coinsurance apply	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.	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)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply	Not covered
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's contraception is covered as preventive, and Men's contraception is covered in full after annual deductible has been satisfied	Deductible and coinsurance apply Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply

Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. No copay, deductible and coinsurance apply	**Inpatient:** Day limits shared with preferred provider network Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with preferred provider network, 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.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply **Outpatient Surgery:** See Hospital services; Outpatient surgery section Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	Covered in full	Covered in full
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Deductible applies	**Telemedicine:** Applicable cost shares apply **Telephone Services and Online (E-Visits):** Not covered