Benefit Summary

Industry Health Trusts Administered by BHT July KP Plus 250
Group Number: SP03600

KAISER PERMANENTE®

Effective Date 7/1/2026 | **Health Plan** KP Plus | **Ref** RQ-212212

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	In-Network	Out-of-Network
Plan deductible	Individual deductible: $250 per calendar year Family deductible: $750 per calendar year	Not applicable
Individual deductible carryover	4th quarter carryover does not apply	Not applicable
Plan coinsurance	Plan pays 90%, you pay 10%	Not applicable
Deductible and/or coinsurance waiver riders	Deductible and coinsurance do not apply to office visits	Not applicable
Out-of-pocket limit	Individual out-of-pocket limit: $3,000 Family out-of-pocket limit: $9,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Not applicable
Pre-existing condition (PEC) **waiting period**	No PEC	Not applicable
Lifetime maximum	Unlimited	Not applicable
Outpatient services (Office visits)	$15 copay primary/$25 copay specialty, deductible and coinsurance do not apply	$35 copay primary/$45 copay specialty, limited to certain benefits up to a combined maximum of 10 services per year.
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** Not covered **Outpatient surgery:** Not covered
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred/preferred specialty/non-preferred specialty $15/$40/$60/$150/30% per 30 day supply	Preferred generic/preferred brand/non-preferred $35/$60/$80 copay; Specialty drugs are not covered. Limited to 5 prescription fills up to a 30-day supply per year.
Prescription mail order	2x prescription cost share per 90 day supply	Not covered
Acupuncture	Covered up to 12 visits per calendar year $15 copay, deductible and coinsurance do not apply	$35 copay, limited to certain benefits up to a combined maximum of 10 services per year.
Ambulance services	Plan pays 80%, you pay 20%	Same as in-network
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $15 copay, deductible and coinsurance do not apply	**Inpatient:** Not covered **Outpatient:** $35 copay, limited to certain benefits up to a combined maximum of 10 services per year.
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%	Not covered

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.	Not covered
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** $15 copay; MRI/PET/CT: $100 copay 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:** Not covered **Outpatient:** $35 copay, limited to 10 covered services per year, combined. MRI/PET/CT: Not covered
Emergency services (copay waived if admitted)	$0 copay Deductible and coinsurance apply	Same as in-network
Hearing exams (routine)	$15 copay, deductible and coinsurance do not apply	$35 copay, limited to certain benefits up to a combined maximum of 10 services per year.
Hearing hardware	1 aid per ear every 36 months; Covered at 80%	Not covered
Home health services	Covered in full up to 130 visits total per calendar year	Not covered
Hospice services	Covered in full	Not covered
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 12 visits per calendar year without prior authorization $15 copay, deductible and coinsurance do not apply	$35 copay, limited to certain benefits up to a combined maximum of 10 services per year.
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $15 copay, deductible and coinsurance do not apply. Routine care not subject to outpatient services copay.	**Inpatient:** Not covered **Outpatient:** $35 copay, limited to certain benefits up to a combined maximum of 10 services per year. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $15 copay, deductible and coinsurance do not apply	**Inpatient:** Not covered **Outpatient:** $35 copay, limited to certain benefits up to a combined maximum of 10 services per year.
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $15 copay, deductible and coinsurance do not apply	$35 copay, limited to certain benefits up to a combined maximum of 10 services per year.
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:** $15 copay, deductible and coinsurance do not 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	Covered in full, limited to certain benefits up to a combined maximum of 10 services per year. 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: Covered in full
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. $15 copay primary/$25 copay specialty, deductible and coinsurance do not apply	**Inpatient:** Not covered **Outpatient:** $35 copay primary/$45 copay specialty, limited to certain benefits up to a combined maximum of 10 services per year.
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Not covered

Sterilization (vasectomy, tubal ligation)	Covered in full	**Inpatient:** Not covered **Outpatient:** $35 copay, limited to certain benefits up to a combined maximum of 10 services per year. **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:** $15 copay, deductible and coinsurance do not apply	**Inpatient:** Not covered **Outpatient:** Not covered
Tobacco cessation counseling	Quit for Life Program - covered in full	Covered in full, limited to certain benefits up to a combined maximum of 10 services per year.
Routine vision care (1 visit every 12 months)	$15 copay, deductible and coinsurance waived	$35 copay, limited to certain benefits up to a combined maximum of 10 services per year.
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Covered in full	**Telemedicine:** $35 copay primary/$45 copay specialty, limited to certain benefits up to a combined maximum of 10 services per year. **Telephone Services and Online (E-Visits):** Not covered