Benefit Summary

Industry Health Trusts Administered by BHT January Summit PPO 1500
Group Number: SP03500

KAISER PERMANENTE®

Effective Date 1/1/2026	**Health Plan** Summit PPO	**Ref** RQ-208676

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**	**Outside Network**
Plan deductible	Individual deductible: $1,500 per calendar year Family deductible: $3,000 per calendar year	Individual deductible: $4,500 per calendar year Family deductible: $9,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 90%, you pay 10% preferred; Plan pays 70%, you pay 30% in-network. Preferred benefit applies when services are provided by a preferred in-network provider.	Plan pays 50%, you pay 50% of the Allowed Amount.
Deductible and/or coinsurance waiver riders	Deductible and coinsurance do not apply to outpatient visits, deductible does not apply to lab/xray	Not applicable
Out-of-pocket limit	Individual out-of-pocket limit: $5,000 Family out-of-pocket limit: $10,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	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
Pre-existing condition (PEC) **waiting period**	No PEC	Same as in-network
Lifetime maximum	Unlimited	Same as in-network maximum
Outpatient services (Office visits)	$20 copay preferred, $40 copay in-network primary/$40 copay preferred, $80 copay in-network specialty, deductible and coinsurance do not apply	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred/preferred specialty/non-preferred specialty $10/$20/$30/$150/30% preferred, $20/$40/$60/$150/30% in-network up to a 30 day supply	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; After 1st fill, maintenance drugs must be filled through KFHPWA mail order or KP retail pharmacies	Not covered
Acupuncture	Covered up to 12 visits per calendar year $40 copay, deductible and coinsurance do not apply	Visit limits shared with in-network
Ambulance services	Deductible and coinsurance apply	Same as in-network
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay preferred, $40 copay in-network, deductible and coinsurance do not 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:** Coinsurance applies 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)	$150 copay Deductible and coinsurance apply	$150 copay In-network deductible and coinsurance apply
Hearing exams (routine)	$20 copay preferred, $40 copay in-network, deductible and coinsurance do not apply	No copay, deductible and coinsurance apply
Hearing hardware	1 aid per ear every 36 months; Plan coinsurance applies	Not covered
Home health services	No visit limit, deductible and coinsurance apply	No visit limit 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 8 visits per calendar year without prior authorization; additional visits when approved by the plan $40 copay, deductible and coinsurance do not apply	Visit limits shared with in-network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay preferred, $40 copay in-network, deductible and coinsurance do not apply. Routine care not subject to outpatient services copay.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay preferred, $40 copay in-network, deductible and coinsurance do not apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	$40 copay, deductible and coinsurance do not 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:** $20 copay preferred, $40 copay in-network, 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	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. $20 copay preferred, $40 copay in-network primary/$40 copay preferred, $80 copay in-network specialty, deductible and coinsurance do not apply	**Inpatient:** Day limits shared with in-network Deductible and coinsurance apply **Outpatient:** Visit limits shared with in-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 in-network, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full	**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:** $20 copay preferred, $40 copay in-network, deductible and coinsurance do not 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)	$0 copay preferred, $40 copay in-network, deductible and coinsurance waived	Deductible and coinsurance apply
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:** Applicable cost shares apply **Telephone Services and Online (E-Visits):** Not covered