## Benefit Summary Seattle Police Officers Guild Retirees Group Number: 0453100

## KAISER PERMANENTE

 Effective Date
 1/1/2025
 Health Plan
 Core HMO
 Ref
 RQ-202352

 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.

Kaiser Permanente believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010. Questions regarding this status may be directed to Member Services (888) 901-4636. You may also contact the Employee Benefits Security Administration, U.S.Department of Labor at (866) 444-3272 or <a href="http://www.dol.gov/ebsa/healthreform">http://www.dol.gov/ebsa/healthreform</a>.

Benefits	Inside Network
Plan deductible	No annual deductible
Individual deductible carryover	Not applicable
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	Individual out-of-pocket limit: \$750 Family out-of-pocket limit: \$1,500 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:
	Plan coinsurance, emergency services at a Managed Health Care Network (MHCN) facility and ambulance services.
Pre-existing condition (PEC) waiting period	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	No сорау
Hospital services	Inpatient services: Covered in full Outpatient surgery: Covered in full
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand \$3 copay per 30 day supply
Prescription mail order	3 x prescription cost share per 90 day supply
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan Covered in full
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	Inpatient: Covered in full Outpatient: Covered in full

supplies         Covered at 80%, orthotics covered when medically necessary           • Orthopadic appliances         Covered at 80%, orthotics covered when medically necessary           • Orthopadic appliances         Prost-mastedomy the similated to two (2) every six (8)           • Ostomy 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 benetil time, it debits supplies. When Devices, equipment and supplies or Prescription drugs are covered and whave benetil time, it debits supplies. When Devices, equipment and supplies or Prescription drugs are covered and whave benetil time, it debits supplies. When Devices, equipment and supplies or Prescription drugs are covered and the benetil time, it debits supplies. When Devices, equipment and supplies or Prescription drugs are covered and the benetil time, it debits supplies are not subject to these limits.           Diagnestic lab and X-ray services         Stopp at a designated facility Haring cases (copp) at a designated facility (Copp) waved if admitted)           Haring cases         Sto Copp at a designated facility Haring cases           Haring cases         Stopp at a designated facility Haring cases           Hearing tasks         Stopp at a designated facility Haring cases           Haring tasks         Stopp at a designated facility Haring cases           Haring tasks         Stopp at a designated facility Haring cases           Haring taservices         Stopp	Devices, equipment and	
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Diagnostic lab and X-rag services         Outpatient: Covered in full           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         \$252 copay at a designated facility (20pa) waived if admitted)           Hearing scama (routine)         Covered in full           Hearing scama (routine)         Covered in full.           Hearing scama (routine)         Covered in full.           Hospice services         Covered in full.           Massage services         Not covered           Massage services         See Rehabilitation services           Maternity services         Covered in full.           Outpatient: Covered in full.         Not covered           Maternity services         Inpattent: Covered in full.           Outpatient: Covered in full.         Not covered           Outpatient: Covered in full.         Outpatient: Covered in full.           Outpatient: Covered in full.         Not covered           Naturopathy         Covered in full.           Outpatient: Covered in full.         Not covered           Newborn Services         Any applicable coinsurance applies to the newborn while both mother and baby are confined. Otherwise, all applicable inpatient: covered in full.           Organ transplants </td <td></td> <td></td>		
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(copay waived if admitted)       \$75 copay at a non designated facility         Hearing exams (routine)       Covered in full         Hearing hardware       \$1.000 per ear every 36 months         Home health services       Covered in full. No visit limit.         Hospice services       Covered in full.         Covered in full.       Not covered.         Manipulative therapy       Covered in full.         Massage services       See Rehabilitation services.         Maternity services       Inpatient: Covered in full.         Maternity services       Inpatient: Covered in full.         Mutropathy       Covered in full.         Outpatient: Covered in full.       Outpatient: Covered in full.         Mutropathy       Covered in full.         Naturopathy       Covered in full.         Newborn Services       Any applicable coinsurance applies to the newborn while both mother and baby are confined. Otherwise, all applicable inpatient cost shares apply. Office Visits: See Outpatient Services; Routine well care: See Preventive care.         Obseity-rolated surgery       Covered in full.         Organ transplants       Unlimited, no waiting period         Inpatient: Covered in full.       Outpatient: Covered in full.         Outpatient: 60 days per calendar year. Services with mental health diagnoses are covered with no limit.         Covered in ful		
Hearing hardware       \$1.000 per ear every 36 months         Home health services       Covered in full         Hospice services       Covered in full         Infertility services       Not covered         Manipulative therapy       Covered up to 10 visits per calendar year without prior authorization Covered in full         Massage services       See Rehabilitation services         Maternity services       Inpatient: Covered in full         Outpatient: Covered in full       Outpatient: Covered in full         Outpatient: Covered in full       Outpatient: Covered in full         Naturopathy       Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan Covered in full         Newborn Services       Any applicable coinsurance applies to the newborn while both mother and baby are confined. Otherwise, all applicable inpatient cost shares apply. Office visits: See Outpatient Services; Routine well care: See Preventive care.         Obesity-related surgery       Covered in full         Unlimited, no waiting period       Inpatient: Covered in full         Outpatient: Covered in full       Covered in full         Preventive care       Covered in full         Outpatient: Covered in full       Inpatient: Covered in full         Outpatient: Covered in full       Inpatient: Covered in full         Preventive care       C		
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Organ transplantsInpatient: Covered in full Outpatient: Covered in fullPreventive care Well-care physicals, immunizations, Pap smear exams, manmogramsCovered in fullRehabilitation services 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 Covered in fullSkilled nursing facilityCovered in full up to 60 days per calendar yearImpatient: Covered in fullImpatient: 60 visits per calendar yearImpatient: 60 visits per calendar year.Services with mental health diagnoses are covered with no limit Covered in fullSkilled nursing facilityCovered in full up to 60 days per calendar yearImpatient: Covered in fullImpatient: Covered in full		Covered at cost shares when medical criteria is met
Impatient: Covered in full         Outpatient: Covered in full         Preventive care         Well-care physicals, immunizations, Pap smear exams, mammograms       Covered in full         Rehabilitation services       Inpatient: 60 days per calendar year. Services with mental health diagnoses are covered with no limit Covered in full         Rehabilitation visits are a total of combined therapy visits per calendar year       Outpatient: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit Covered in full         Skilled nursing facility       Covered in full up to 60 days per calendar year         Sterilization (vasedomy       Inpatient: Covered in full		Unlimited, no waiting period
Well-care physicals, immunizations, Pap smear exams, mammograms       Covered in full         Rehabilitation services       Inpatient: 60 days per calendar year. Services with mental health diagnoses are covered with no limit Covered in full         Rehabilitation visits are a total of combined therapy visits per calendar year.       Services with mental health diagnoses are covered with no limit Covered in full         Skilled nursing facility       Covered in full up to 60 days per calendar year         Starilization (vasectomy)       Inpatient: Covered in full	Organ transplants	
Rehabilitation services       Inpatient: 60 days per calendar year. Services with mental health diagnoses are covered with no limit         Rehabilitation visits are a total of combined therapy visits per calendar year.       Outpatient: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit         Skilled nursing facility       Covered in full         Covered in full       Covered in full         Starilization (vasectomy       Inpatient: Covered in full	Well-care physicals, immunizations, Pap smear	Covered in full
Covered in full         Rehabilitation visits are a total of combined therapy visits per calendar year         Outpatient: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit Covered in full         Skilled nursing facility       Covered in full up to 60 days per calendar year         Inpatient: Covered in full       Inpatient: Covered in full		
Rehabilitation visits are a total of combined therapy visits per calendar year.       Outpatient: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit Covered in full         Skilled nursing facility       Covered in full up to 60 days per calendar year         Inpatient: Covered in full       Inpatient: Covered in full	Renabilitation services	
Skilled nursing facility       Covered in full up to 60 days per calendar year         Starilization (vasectomy       Inpatient: Covered in full	total of combined therapy	Outpatient: 60 visits per calendar year. Services with mental health diagnoses are covered with no limit
Starilization (vasectomy Inpatient: Covered in full		
tubal ligation) Outpatient: Covered in full Outpatient Surgery: See Hospital services; Outpatient surgery section	Sterilization (vasectomy,	Inpatient: Covered in full Outpatient: Covered in full

Temporomandibular Joint (TMJ) services	Inpatient: Covered in full Outpatient: Covered in full	
Tobacco cessation counseling	Covered in full	
Routine vision care (1 visit every 12 months)	Covered in full	
<b>Optical hardware</b> Lenses, including contact lenses and frames	Members under 19: 1 pair of frames and lenses per year or contact lenses covered at 50% coinsurance Members age 19 and over: \$100 per 12 months	
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Covered in full	
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