Benefit Summary
NEXCOM
Group Number: 2331900

KAISER PERMANENTE®

Effective Date 1/1/2027	**Health Plan** Core HMO	**Ref** RQ-215327

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**
Plan deductible	Individual deductible: $500 per calendar year Family deductible: $1,000 per calendar year
Individual deductible carryover	4th quarter carryover applies
Plan coinsurance	Plan pays 80%, you pay 20%
Out-of-pocket limit	Individual out-of-pocket limit: $4,500 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
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$20 copay primary/$50 copay specialty, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $10/$35/$70 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 12 visits per calendar year $20 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 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	Covered at 80%
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 **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)	$100 copay at a designated facility $100 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$20 copay, deductible and coinsurance apply
Hearing hardware	1 aid per ear every 36 months; Covered at 80%
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $20 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 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 $20 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)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay, deductible and coinsurance apply
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
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 primary/$50 copay specialty, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$20 copay, deductible and coinsurance waived
Optical hardware 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:** $150 per 12 months Not subject to deductible and coinsurance
Virtual Care Including Telemedicine, Telephone Services and Online (E-Visits)	Covered in full