

<b>Effective Date</b>	07/01/2024	7/1/2024
<b>Renewal Date</b>	07/01/2025	7/1/2025
<b>Carrier</b>	<b>Kaiser Permanente Insurance Company</b>	<b>Kaiser Permanente Insurance Company</b>
<b>Plan Name</b>	DHMO 2500 Virtual Complete w/Chiro	DHMO HSA
<b>Eligible Class</b>	Eligible Employees	Eligible Employees

**General Plan Information**

Annual Deductible/Individual	\$2,500	\$1600 medical/prescription combined
Annual Deductible/Family	\$2,500 for each member in a family of two or more members. \$5,000 for an entire family of two or more members.	\$3200 medical/prescription combined
Coinsurance	80%	90%
Office Visit/Exam	\$40 copay after Plan Deductible (Plan Deductible doesn't apply to the first three visits combined for primary care, urgent care, mental health and substance use disorder treatment services.)	90% after deductible
Outpatient Specialist Visit	\$40 copay after Plan Deductible	90% after deductible
Annual Out-of-Pocket Limit/Individual	\$5,500	\$3,200
Annual Out-of-Pocket Limit/Family	\$5,500 for each member in a family of two or more members. \$11,000 for an entire family of two or more members.	\$6,400
Deductible Included in Out-of-Pocket Limits	Yes	Yes
Lifetime Plan Maximum		Unlimited
High Deductible Health Plan	No	Yes

**Outpatient Services**

**Preventive Services**

Well-Child Care	100% deductible waived through age 23 months	100% through age 23 months; deductible waived
Immunizations	100% deductible waived	100% deductible waived
Well Woman Exams	100% deductible waived	100% deductible waived
Mammograms	100% for preventive, deductible waived	100% for preventive; deductible waived for preventive
Adult Periodic Exams with Preventive Tests	100% deductible waived	100% deductible waived
Diagnostic X-Ray and Lab Tests	100% for preventive, deductible waived; all other X-rays 80% after deductible and \$15 per encounter for most lab tests	100% preventive X-rays deductible waived; other than preventive 90% after deductible

**Maternity Care**

Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%
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**Inpatient Hospital Services**

Inpatient Hospitalization	80% after deductible	90% after deductible
Pre-Authorization of Services Required	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	80% after deductible	90% after deductible

**Surgical Services**

Outpatient Facility Charge	80% after deductible	90% after deductible
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**Emergency Services**

Emergency Room	80% after deductible	90% after deductible
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Air	80% after deductible	90% after deductible
Ground	80% after deductible	90% after deductible
<b>Urgent Care</b>		
Urgent Care Facility	\$40 copay after deductible	90% after deductible
<b>Mental Health Benefits</b>		
Inpatient Care	80% after deductible	90% after deductible
Outpatient Care	After deductible, \$40 per visit for individual and \$20 per visit for group treatment	90% after deductible
<b>Substance Abuse</b>		
<b>Inpatient Care</b>		
Inpatient Hospitalization	80% after deductible	90% after deductible
Inpatient Detoxification Services	80% after deductible	90% after deductible
<b>Outpatient Care</b>		
Outpatient Services	After deductible, \$40 per visit for individual and \$20 per visit for group treatment	90% after deductible
<b>Prescription Drug Benefits</b>		
Prescription Drug Deductible	None	\$1,600 ind/\$3,200 fam; medical/prescription combined
Prescription Drug Annual Out-of-Pocket Limit/Individual		\$1,000
Prescription Drug Annual Out-of-Pocket Limit/Family Generic	\$15 copay	\$2,000
Brand (Formulary/Preferred)	\$40 copay after plan deductible	\$10 copay; after deductible
Brand (Non-Formulary/Non-preferred)		\$30 copay; after deductible
Number of Days Supply	30 days	30 days
<b>Mail Order</b>		
Mail Order Mandatory Generic	\$30 copay	N/A
Brand (Non-Formulary/Non-preferred)	\$80 copay after plan deductible	\$20 copay; after deductible
Number of Days Supply for Mail Order	100 days	\$60 copay; after deductible
100 days		100 days
<b>Other Services and Supplies</b>		
Durable Medical Equipment & Prosthetic Devices	80% deductible waived	90% after deductible; limited to \$2,500 calendar year benefit
Home Health Care	100% limited to 100 visits/calendar year; deductible waived	100% after deductible; limited to 100 visits/calendar year

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### Summary of the Kaiser Permanente DHMO 2500 Virtual Complete and DHMO HSA - Eligible Employees

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Skilled Nursing or Extended Care Facility	80% deductible waived	90% after deductible; limited to 100 days/benefit period
Hospice Care	100% deductible waived	100% after deductible
Chiropractic Services	80% after deductible; limited to 100 days/benefit period	Not covered
Acupuncture	100% deductible waived	Not covered
<b>Infertility</b>		
Diagnosis	See plan certificate	See plan certificate
Treatment	See plan certificate	See plan certificate
<b>Outpatient Rehabilitative Therapy Services</b>		
Physical	\$20 copay; after deductible	90% after deductible
Occupational	\$20 copay; after deductible	90% after deductible
Speech	\$20 copay; after deductible	90% after deductible