Summary of Benefits[43]

Individual and Family Plan
HMO Plan

Gold 80 HMO

The Summary of Benefits sets forth the Member's share-of-costs for Covered Services under this benefit plan and represents only a brief description of the benefit plan. Please read the Evidence of Coverage (EOC) carefully for a complete description of provisions, benefits, exclusions, prior authorization and other important information pertaining to this benefit plan.

Medical Provider Network:	L.A. Care Network
Vision Network:	VSP
Behavioral Health Network:	Carelon
Pediatric Dental Network:	Liberty Dental
Pharmacy Network:	Navitus
Drug Formulary:	Standard Formulary

Calendar Year Deductibles [2,11]

A Calendar Year Deductible is the amount a Member pays each Calendar Year before L.A. Care pays for Covered Services under the Plan.

		When using a Participating Provider[3,11]
Calendar Year Deductible	*Individual coverage*	$0
	Family coverage	$0: individual $0: Family
Calendar Year Pharmacy Deductible	*Individual coverage*	$0
	Family coverage	$0: individual $0: Family

Calendar Year Out-of-Pocket Maximum[4,14]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3,11]
Individual coverage	$8,700
Family coverage	$8,700: individual $17,400: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount L.A. Care will pay for Covered Services.

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Benefits[5]	Your Payment[15] When using a Participating Provider[3,11]	Deductible[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	No
Routine Physical Exam	$0	
Well Child Preventative Exam (up to age 23 months)	$0	
Physician services[22]		
Primary care office visit	$35/visit	No
Specialist care office visit[36]	$65/visit	
Physician or surgeon services in an Outpatient Facility	$60/visit	
Physician or surgeon services in an Inpatient Facility	$0/visit	
Other professional services		
Other practitioner office visit[35]	$35/visit	No
Includes nurse practitioners, physician assistants, and therapists.		
Acupuncture services	$35/visit	
Family planning	$0	
Allergy Testing and Treatment		
Allergy serum purchased separately for treatment	20%	
Office visits (includes visits for allergy serum injections)	$65/visit	
Podiatric services	$35/visit	
Pregnancy and maternity care		
Physician office visits: prenatal and initial postnatal: including pre-natal diagnosis of genetic disorders in cases of high-risk	$0	No
Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy	$350/day up to 5 days	
Routine newborn circumcision[7]	$60	
Termination of pregnancy-related services	$0	
Emergency Services		
Emergency room services *(copay waived if admitted)*	$330/visit	No
Emergency room Physician services	$0	
Urgent care center services	$35/visit	No
Ambulance services[16] *This payment is for emergency or authorized non-emergency transport.*	$250/transport	No

	When using a Participating Provider[3,11]	Deductible[2] applies
Outpatient facility services		
Ambulatory Surgery Center	$130/surgery	No
Outpatient Department of a Hospital: surgery	$130/surgery	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies[21]	20%	
Inpatient facility services[19,20]		
Hospital services and stay (Including gender affirming care, bariatric surgery, Temporomandibular Joint Disorder (TMJ), and reconstructive surgery)	$350/day up to 5 days	No
Diagnostic x-ray, imaging, pathology, and laboratory services		
• Outpatient Laboratory and Pathology • *Diagnostic Laboratory services are covered per service or per test when provided to diagnose illness and injury*	$40/visit	No
• Outpatient diagnostic X-ray and imaging • *Including mammography and ultrasounds performed in Outpatient Radiology Center or Outpatient Hospital*	$75/visit	
• Medical Imaging Services • *Including CT, PET scans, MRIs, and Nuclear Medicine Imaging performed in the Outpatient department of a Hospital or free-standing outpatient center. Prior authorization is required.*	$75/visit	
Rehabilitative and habilitative services		
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.		
Office location	$35/visit	No
Outpatient Department of a Hospital	$35/visit	
Rehabilitation unit of a Hospital for Medically Necessary days	$350/day up to 5 days	
In an Inpatient facility, this Co-payment is billed as part of Inpatient Hospital Services		
Durable medical equipment (DME)		
DME *(Includes but not limited to Prosthetics, Orthotics, insulin pumps, etc.)*	20%	No
Breast pump	$0	

	When using a Participating Provider[3,11]	Deductible[2] applies

Home health care services
Up to a combined Benefit maximum of 100 visits per Member, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services. If your benefit plan has a Calendar Year Medical Deductible, the number of days starts counting toward the maximum when the services are first provided even if the Calendar Year Medical Deductible has not been met.
• Home Health Care agency services, including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist
• Home Infusion/Home Injectable Therapy Benefits (e.g., blood factor and other home infusion products and associated medical supplies)
  • Home visits by an infusion nurse (Home infusion agency nursing visits are not subject to the Home Health Care and Home Infusion/Home Health Injectable Services Calendar Year visit limitation.)
  • Medical supplies associated with infusion/injectable therapy
  • Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit and standard member copayments apply
	$30/visit	No

Skilled Nursing Facility (SNF) services[19] *Up to a Benefit maximum of 100 days per Member, per Calendar Year.* *These Services have a Calendar Year day maximum except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether rendered in a Hospital or a free-standing Skilled Nursing Facility.* *If your benefit plan has a Calendar Year Medical Deductible, the number of days start counting toward the maximum when the services are first provided even if the Calendar Year Medical Deductible has not been met.*	$150/day up to 5 days /admission	No
Hospice program services[18] *Covered Services for Members who have been accepted into an approved Hospice Program. All Hospice Program Benefits must be prior authorized by L.A. Care and must be received from a Participating Hospice Agency* *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, Palliative care, and inpatient respite care.*	$0	No
Other services and supplies Diabetes care services		
• Devices, equipment, and supplies	20%	No
• Self-management training[17]	$0	No
• Medical nutrition therapy[17]	$0	No

Mental Health and Substance Use Disorder Benefits

Mental health and substance use disorder Benefits are provided through Carelon.	Your Payment[15] When using a Carelon Participating Provider[3,11]	Deductible[2] applies
Outpatient services		
Office visit, including Physician office visit	$35/visit	No
Other outpatient services[44], including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment[26] for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$35/visit	No
Partial Hospitalization Program[25]	$35/visit	No
Psychological Testing	$35/visit	No
Inpatient services		
Physician inpatient services	$0	No
Hospital services	$350/day up to 5 days	No
Residential care[24]	$350/day up to 5 days	No

Prescription Drug Benefits[7,8,27,28,29,30,31,32,33]

	Your Payment[15] When using a Participating Pharmacy[3,11]	Deductible[2] applies
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply. Note: If the retail price for a covered prescription drug, supply, or supplement is less than the co-payment, you will pay the lesser amount. The amount you pay will be applied to your out-of-pocket maximum limit.		
Contraceptive Drugs and devices[34]	$0	No
Tier 1 Drugs (Most Generics)	$15/prescription	No
Tier 2 Drugs (Preferred Brand)	$60/prescription	No
Tier 3 Drugs (Non-preferred Brand)	$85/prescription	No
Tier 4 Drugs (Specialty Drugs—Prior Authorization is required)	20% up to $250/prescription	No
Tier four shall consist of drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply.		
Mail service pharmacy prescription Drugs		
Per prescription, up to a 90-day supply.		
Contraceptive Drugs and devices[34]	$0	No
Tier 1 Drugs (Most Generics)	$30/prescription	No
Tier 2 Drugs (Preferred Brand)	$120/prescription	No
Tier 3 Drugs (Non-Preferred Brand)	$170/prescription	No

Pediatric Benefits	Your Payment[15]	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Dentist[3,11]**	**Deductible[2] applies**
Pediatric dental[9,39,40]		No
Diagnostic and preventive services		
• Oral exam	$0	
• Preventive – cleaning	$0	
• Preventive – x-ray	$0	
• Sealants per tooth	$0	
• Topical fluoride application	$0	
• Space maintainers - fixed	$0	
Basic services • Restorative procedures • Periodontal maintenance • Adjunctive general services	See Dental Copay Schedule in Evidence of Coverage	
Major services • Oral surgery • Endodontics • Periodontics (other than maintenance) • Crowns and casts • Prosthodontics	See Dental Copay Schedule in Evidence of Coverage	
Orthodontics (Medically Necessary)[41]	$1,000	
Pediatric vision[10,38]		No
Comprehensive eye examination *One exam per Calendar Year.*		
• Ophthalmologic visit	$0	
• Optometric visit	$0	
Prescription Glasses *Includes frames and lenses (one pair per year)*	$0	
Contact Lenses	$0	
Including medically necessary contact lenses for the treatment of keratoconus pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism)		

Definitions

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (Deductible):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before L.A. Care pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a "Yes" in the Benefits chart above.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, L.A. Care will pay 100% of the Allowed Charges for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowed Charges, and charges for services above any Benefit maximum.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year. Any amount you have paid toward the individual OOPM will be applied to both the individual OOPM and the Family OOPM.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

7 Routine newborn circumcision

Routine newborn circumcision performed in the office, ASC or outpatient hospital Facility copayment applies when services are performed in an outpatient surgical facility.

8 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to L.A. Care for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out- of-Pocket Maximum.

Request for Medical Necessity Review. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Oral Anticancer Drugs. You pay up to $250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral

Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

9 Pediatric Dental Coverage:

Pediatric dental Benefits are provided through L.A. Care's Dental Plan Administrator (DPA).

Orthodontic Covered Services. The Copayment or Coinsurance for Medically Necessary orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

This plan is compliant with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of Medical Necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

10 Pediatric Vision Coverage:

Pediatric vision Benefits are provided through L.A. Care's Vision Plan Administrator (VPA).

Coverage for frames. If frames are selected that are more expensive than the Allowable Amount established for frames under this Benefit, you pay the difference between the Allowable Amount and the provider's charge.

"Collection frames" are covered with no Member payment from Participating Providers. Retail chain Participating Providers do not usually display the frames as "collection," but a comparable selection of frames is maintained.

"Non-collection frames" are covered up to an Allowable Amount of $150; however, if the Participating Provider uses:

- wholesale pricing, then the Allowable Amount will be up to $99.06.
- warehouse pricing, then the Allowable Amount will be up to $103.64.

Participating Providers using wholesale pricing are identified in the provider directory.

Plans may be modified to ensure compliance with State and Federal requirements.

11 Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the issuer.

12 Member is responsible for all charges when receiving out-of-network care, unless services rendered are deemed a medical emergency or services rendered are approved by the Plan. In some cases, a non-plan provider may provide covered services at an in-network facility where you have been authorized to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at in-network facilities where you have been authorized to receive care.

13 Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.

14 In coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out-of-pocket contribution is limited to the individual's annual out-of-pocket maximum. After a family satisfies the family out-of- pocket maximum, the issuer pays all costs for covered services for all family members.

15 Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.

16 Coverage for transportation by airplane, passenger car, taxi or other form of public transportation is not covered.

17 The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self- management training, education, and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.

18 The cost sharing for hospice services applies regardless of the place of service.

19 In the Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

20 The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility. For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.

21 The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services

22 Initial outpatient/office visit to diagnose or determine treatment does not require prior authorization. Routine office- based outpatient care to diagnose or treat mental health or substance use disorders does not require pre-authorization when rendered by an in-network provider. There is no limit on the number of outpatient/office visits.

23 Covered California may approve deviations from the benefit plan designs for certain services on a case by case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA)

24 Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services

25 Outpatient Partial Hospitalization Services include short-term hospital-based intensive outpatient care. For Outpatient Partial Hospitalization Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program and ends on the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates would constitute an episode of care. If the patient needs to be readmitted at a later date, then this would constitute another episode of care.

26 Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.

27 For drugs to treat an illness or condition the copay or co-insurance applies to an up to 30-day prescription supply. For example, if the prescription is for a month's supply, one co-pay or co-insurance can be collected. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.

28 Drug tiers are defined as follows:

Tier	Definition
	1) Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs
	2) Preferred brand name drugs and;
	3) Drugs that are recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
	1) Drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies
	2) Drugs that require the enrollee to have special training, clinical monitoring
	3) Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

*Some drugs may be subject to zero cost-sharing under the preventive services rules.

29 Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted

30 A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary

31 Member cost-share for oral anti-cancer drugs shall not exceed $250 for a script up to 30 days per state law (Health and Safety Code §1367.656 Insurance Code §10123.206).

32 If a provider authorizes a Brand Name drug that is not deemed medically necessary by the Plan, the Member has the choice of accepting a Generic Drug alternative, or the Member is responsible to pay their applicable copay for the Brand Name drug equivalent.

33 For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.

34 There is no co-payment or Coinsurance for contraceptive drugs and devices, however, if a Brand Name contraceptive drug is requested when a Generic Drug equivalent is available, the Member is responsible to pay their applicable copay for the Brand Name contraceptive drug equivalent. In addition, select contraceptives may require prior authorization to be covered without a co-payment or Coinsurance.

35 The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, Podiatrists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

36 Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by

specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

37 This includes pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints.

38 Well vision exam, frames and lenses available once per calendar year. Lenses include single vision, lined bifocal or lenticular, polycarbonate, plastic or glass covered in full, UV and scratch covered in full. Frames from a Pediatric Exchange Collection covered in full. Contact lenses, in lieu of glasses are covered in full. Standard, one pair annually. Monthly (6-month supply), Bi-weekly (3-month supply) and Dailies (1-month supply). Limitations include the following: two pairs of glasses instead of bifocals, replacement of lenses, frames or contacts, medical or surgical treatment, orthoptics, vision training or supplemental testing. Items not covered under contact lens coverage: insurance policies or service agreements, artistically painted or non-prescription lenses, additional office visits for contact lens pathology and contact lens modification, polishing or cleaning. Laser vision correction discount, 15% off of regular price or 5% off of promotional price; discounts only available from contracted facilities.

39 As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non- dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.

40 A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2025 Dental Copay Schedule.

41 Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

42 For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.

43 Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Design.

44 Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.

45 The out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2025 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223

46 Where indicated, the deductible is waived for the first three non-preventive visits, which may include primary care visits, other practitioner office visits, specialist visits, urgent care visits or outpatient Mental Health/Substance Use Disorder visits.\

47 These Endnotes do not limit an issuer's obligation to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirement of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.