Family Coverage

Proposed Benefit Summary

Benefit Plan 9991 \$30 OV, \$500 ADMIT, \$200 ER, \$15/\$35/30% RX

Principal Benefits for Kaiser Permanente Traditional HMO Plan (1/1/25—12/31/25)

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Self-Only Coverage

Family Coverage

Plan Dut-of-Pocket Maximum \$2,500 \$5,000 Plan Deductible None None None None Drug Deductible None None None None Drug Deductible None None None None Plan Provider Office Visits You Pay Most Primary Care Visits and most Non-Physician Specialist Visits. \$30 per visit Most Physician Specialist Visits S30 per visit Most Physician Specialist Visits S30 per visit Most Physician Specialist Visits No charge Well-child preventive exams (through age 23 months) No charge Scheduled prenatal care exams. No charge Routine eye exams with a Plan Optometrist. No charge Routine eye exams with a Plan Optometrist. No charge Well-child prevaluations, evaluations, and treatment S30 per visit Most physical, occupational, and speech therapy S30 per visit Most physical, occupational, and speech therapy S30 per visit Most physical, occupational, and speech therapy No charge Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge Physician Specialist Visits by interactive video No charge Physician Specialist Visits by interactive video No charge Physician Specialist Visits by telephone No charge Physician S	Amounts Per Accumulation Period	(a Family of one Member)	Each Member in a Family of two or more Members	Entire Family of two or more Members	
Plan Deductible None Non	Plan Out-of-Pocket Maximum	\$2 500			
Drug Deductible None None None None Plan Provider Office Visits You Pay		• /	. ,		
Most Primary Care Visits and most Non-Physician Specialist Visits. Most Physician Specialist Visits. Well-child preventive exams (through age 23 months). No charge Routine eye exams with a Plan Optometrist. Urgent care consultations, evaluations, and treatment. So per visit Most physicia, occupational, and speech therapy. So per visit Most physicia, occupational, and speech therapy. So per visit You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video. Physician Specialist Visits by interactive video. Physician Specialist Visits by interactive video. Physician Specialist Visits by telephone. No charge No					
Most Physician Specialist Visits Routine physical maintenance exams, including well-woman exams. Well-child preventive exams (through age 23 months). No charge Well-child preventive exams (through age 23 months). No charge Routine eye exams with a Plan Optometrist. No charge Routine eye exams with a Plan Optometrist. No charge Urgent care consultations, evaluations, and treatment. S30 per visit Wost physical, occupational, and speech therapy. S30 per visit Wost physical, occupational, and speech therapy. Vou Pay Primary Care Visits and Non-Physician Specialist Visits by interactive video Physician Specialist Visits by interactive video. No charge Physician Specialist Visits by interactive video. No charge Physician Specialist Visits by telephone. No charge Outpatient surgery and certain other outpatient procedures. S250 per procedure Most Immunizations (including the vaccine) Nost Immunizations (including the vaccine) Nost Immunizations (including the vaccine) Nost immunizations (including the vaccine) No charge Well Preventive X-rays, screenings, and laboratory tests as described in the EOC. No charge Nost and Board of the Scans. S50 per procedure No charge Well Procedure No charge No charge No charge S50 per procedure No charge S50 per procedure You Pay S50 per admission S50 per admission S50 per admission Well Procedure Services You Pay S50 per visit Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share) Ambulance Services You Pay Prescription Drug Coverage Covered outpatient Items in accord with our drug formulary guidelines: Most generic Items (Tier 1) at a Plan Pharmacy. S30 for up to a 30-day supply Most brand-name items (Tier 2) at a Plan Pharmacy. S30 for up to a 10					
Routine physical maintenance exams, including well-woman exams. No charge N	Most Primary Care Visits and most Non-Physician Specialist Visits \$30 per visit				
Well-child preventive exams (through age 23 months) Scheduled prenatal care exams Routine eye exams with a Plan Optometrist Urgent care consultations, evaluations, and treatment Soloper visit Most physical, occupational, and speech therapy Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge Physician Specialist Visits by telephone Physician Specialist Visits by telephone No charge No charge Preventive Services Outpatient surgery and certain other outpatient procedures Most Trays, screenings, and laboratory tests as described in the EOC. No charge MRI, most CT, and PET scans Solo per procedure Preventive X-rays, screenings, and laboratory tests, and drugs. Wou Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. Emergency Gepartment visits Solo per admission Emergency Services Emergency department Cost Share (see "Hospital Inpatient Services", you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share instead of the emergency department visits Most yere in the EOC. Ambulance Services You Pay Covered outpatient items					
Scheduled prenatal care exams					
Routine eye exams with a Plan Optometrist					
Urgent care consultations, evaluations, and treatment \$30 per visit Most physical, occupational, and speech therapy					
Most physical, occupational, and speech therapy					
Telehealth Visits Primary Care Visits and Non-Physician Specialist Visits by interactive video					
Primary Care Visits and Non-Physician Specialist Visits by interactive video			· ·	•	
video	Primary Care Visits and Non-Physician Specialist Visits by interactive				
Primary Care Visits and Non-Physician Specialist Visits by telephone	video		No charge		
Physician Specialist Visits by telephone			No charge		
Outpatient Services You Pay Outpatient surgery and certain other outpatient procedures \$250 per procedure Most X-rays and laboratory tests \$10 per encounter Preventive X-rays, screenings, and laboratory tests as described in the EOC No charge MRI, most CT, and PET scans \$50 per procedure Hospital Inpatient Services You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs \$500 per admission Emergency Services You Pay Emergency department visits \$200 per visit Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share) Ambulance Services You Pay Ambulance Services You Pay Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply Most pand-name items (Tier 2) at a Plan Pharmacy \$30 for up to a 100-day supply Most brand-name items (Tier 2) at a Plan Pharmacy \$70 for up to a 100-day supply Most specialty items (Tier 4) at a Plan Pharmacy \$70 for up to a 100-day supply Most specialty items (Tier 4) at a Plan Pharmacy \$70 for up to a 100-day supply					
Outpatient surgery and certain other outpatient procedures	Physician Specialist Visits by telephone		No charge	No charge	
Most immunizations (including the vaccine)					
Most X-rays and laboratory tests					
Preventive X-rays, screenings, and laboratory tests as described in the EOC					
the EOC					
MRI, most CT, and PET scans					
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs					
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs		·	·		
Emergency Services Emergency department visits	Room and board, surgery, anesthesia, X-rays, laboratory tests, and				
Emergency department visits			\$500 per admission	\$500 per admission	
Emergency department visits	Emergency Services				
instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share) Ambulance Services Ambulance Services Ambulance Services Ambulance Services Ambulance Services Frescription Drug Coverage Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy Most generic (Tier 1) refills through our mail-order service Most brand-name items (Tier 2) at a Plan Pharmacy Most brand-name (Tier 2) refills through our mail-order service Most specialty items (Tier 4) at a Plan Pharmacy Most specialty items (Tier 4) at a Plan Pharmacy Most Specia	Emergency department visits				
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Ambulance Services \$100 per trip Prescription Drug Coverage You Pay Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply Most brand-name items (Tier 2) at a Plan Pharmacy \$30 for up to a 100-day supply Most brand-name (Tier 2) refills through our mail-order service \$70 for up to a 100-day supply Most specialty items (Tier 4) at a Plan Pharmacy \$30% Coinsurance (not to exceed \$250) for up to a					
Prescription Drug Coverage Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy					
Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy					
Most generic items (Tier 1) at a Plan Pharmacy	Prescription Drug Coverage		You Pay		
Most generic (Tier 1) refills through our mail-order service				supply	
Most brand-name items (Tier 2) at a Plan Pharmacy					
Most brand-name (Tier 2) refills through our mail-order service					
Most specialty items (Tier 4) at a Plan Pharmacy					
30-day supply	. , , , ,	•	30-day supply	, ,	

Proposed Benefit Summary	(continued)
Durable Medical Equipment (DME)	You Pay
DME items as described in the EOC	20% Coinsurance
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	\$30 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$30 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge No charge
EOC	
Assisted reproductive technology ("ART") Services	
Hospice care	No charge

This proposal is a summary and does not include all benefits, member cost share, out-of-pocket maximums, exclusions, or limitations. For a complete description, please refer to the *Evidence of Coverage*.