Proposed Benefit Summary

Benefit Plan 17994
$1650 DED, 10% OV, 10% IP, $10/$30/20% RX

Principal Benefits for Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO (1/1/25—12/31/25)

"Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the *EOC*.

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.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$3,300	$3,300	$6,600
Plan Deductible	$1,650	$3,300	$3,300
Drug Deductible	Not applicable	Not applicable	Not applicable

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	10% Coinsurance after Plan Deductible
Most Physician Specialist Visits	10% Coinsurance after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	10% Coinsurance (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	10% Coinsurance after Plan Deductible
Most physical, occupational, and speech therapy	10% Coinsurance after Plan Deductible

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge after Plan Deductible
Physician Specialist Visits by interactive video or telephone	No charge after Plan Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	10% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	10% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)

Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	10% Coinsurance after Plan Deductible

Emergency Services	**You Pay**
Emergency department visits	10% Coinsurance after Plan Deductible

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	10% Coinsurance after Plan Deductible

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$10 for up to a 30-day supply after Plan Deductible
Most generic (Tier 1) refills through our mail-order service	$20 for up to a 100-day supply after Plan Deductible
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply after Plan Deductible

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Proposed Benefit Summary *(continued)*

Prescription Drug Coverage	You Pay
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply after Plan Deductible
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed $250) for up to a 30-day supply after Plan Deductible
Durable Medical Equipment (DME)	**You Pay**
Base DME items as described in the *EOC*	10% Coinsurance after Plan Deductible
Supplemental DME items up to a $2,500 benefit limit per Accumulation Period as described in the *EOC*	10% Coinsurance after Plan Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	10% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	10% Coinsurance after Plan Deductible
Group outpatient mental health treatment	10% Coinsurance after Plan Deductible
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	10% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	10% Coinsurance after Plan Deductible
Group outpatient substance use disorder treatment	10% Coinsurance after Plan Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge after Plan Deductible
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	10% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the *EOC*	No charge after Plan Deductible
Diagnosis and treatment of infertility and artificial insemination	Not covered
Assisted reproductive technology (“ART”) Services	Not covered

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*.