

**Proposed Benefit Summary**

**Benefit Plan 17650**  
**\$8,000 DED, \$0 OV, \$0 IP, \$0/ \$75/ \$250 RX**

**Principal Benefits for Kaiser Permanente Deductible 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.

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.

<b>Amounts Per Accumulation Period</b>	<b>Self-Only Coverage</b> (a Family of one Member)	<b>Family Coverage</b> Each Member in a Family of two or more Members	<b>Family Coverage</b> Entire Family of two or more Members
Plan Out-of-Pocket Maximum	\$8,000	\$8,000	\$16,000
Plan Deductible	\$8,000	\$8,000	\$16,000
Drug Deductible	None	None	None

**Plan Provider Office Visits**

Most Primary Care Visits and most Non-Physician Specialist Visits .....	<b>You Pay</b> No charge (Plan Deductible doesn't apply)
Most Physician Specialist Visits .....	No charge (Plan Deductible doesn't apply)
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)
Scheduled prenatal care exams .....	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist.....	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment .....	No charge (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy .....	No charge (Plan Deductible doesn't apply)

**Telehealth Visits**

Primary Care Visits and Non-Physician Specialist Visits by interactive video .....	<b>You Pay</b> No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video .....	No charge (Plan Deductible doesn't apply)
Primary Care Visits and Non-Physician Specialist Visits by telephone..	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by telephone.....	No charge (Plan Deductible doesn't apply)

**Outpatient Services**

Outpatient surgery and certain other outpatient procedures .....	<b>You Pay</b> No charge after Plan Deductible
Most immunizations (including the vaccine) .....	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests .....	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans .....	\$350 per procedure (Plan Deductible doesn't apply)

**Hospital Inpatient Services**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	<b>You Pay</b> No charge after Plan Deductible
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**Emergency Services**

Emergency department visits .....	<b>You Pay</b> \$500 per visit (Plan Deductible doesn't apply)
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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**

Ambulance Services .....	<b>You Pay</b> \$500 per trip (Plan Deductible doesn't apply)
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**Prescription Drug Coverage**

Covered outpatient items in accord with our drug formulary guidelines:	<b>You Pay</b>
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service .....	No charge for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy .....	\$75 for up to a 30-day supply (Plan Deductible doesn't apply)

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**Proposed Benefit Summary***(continued)***Prescription Drug Coverage****You Pay**

Most brand-name (Tier 2) refills through our mail-order service .....	\$150 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy .....	\$250 for up to a 30-day supply (Plan Deductible doesn't apply)

**Durable Medical Equipment (DME)****You Pay**

DME items as described in the <i>EOC</i> .....	20% Coinsurance (Plan Deductible doesn't apply)
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**Mental Health Services****You Pay**

Inpatient psychiatric hospitalization .....	No charge after Plan Deductible
Individual outpatient mental health evaluation and treatment .....	No charge (Plan Deductible doesn't apply)
Group outpatient mental health treatment .....	No charge (Plan Deductible doesn't apply)

**Substance Use Disorder Treatment****You Pay**

Inpatient detoxification .....	No charge after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment .....	No charge (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment .....	No charge (Plan Deductible doesn't apply)

**Home Health Services****You Pay**

Home health care (up to 100 visits per Accumulation Period) .....	No charge (Plan Deductible doesn't apply)
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**Other****You Pay**

Skilled nursing facility care (up to 100 days per benefit period) .....	No charge after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i> .....	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i> .....	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services .....	Not covered
Hospice care .....	No charge (Plan Deductible doesn't apply)

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*.