

Proposed Benefit Summary**Benefit Plan 19521****\$3,000 DED, 30% OV, 30% IP, 30%/30%/30% RX****Principal Benefits for
Kaiser Permanente Deductible HMO Plan (1/1/26—12/31/26)****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	\$6,000	\$6,000	\$12,000
Plan Deductible	\$3,000	\$3,000	\$6,000
Drug Deductible	None	None	None

Plan Provider Office Visits

Most Primary Care Visits and most Non-Physician Specialist Visits
 Most Physician Specialist Visits
 Routine physical maintenance exams, including well-woman exams
 Well-child preventive exams (through age 23 months)
 Routine eye exams with a Plan Optometrist.....
 Urgent care consultations, evaluations, and treatment
 Most physical, occupational, and speech therapy

You Pay

30% Coinsurance after Plan Deductible
 30% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)
 30% Coinsurance after Plan Deductible
 30% Coinsurance after Plan Deductible

Telehealth Visits

Primary Care Visits and Non-Physician Specialist Visits by interactive
 video or telephone
 Physician Specialist Visits by interactive video or telephone

You Pay

No charge (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)

Outpatient Services

Outpatient surgery and certain other outpatient procedures
 Most immunizations (including the vaccine)
 Most X-rays and laboratory tests
 Preventive X-rays, screenings, and laboratory tests as described in
 the EOC.....

You Pay

30% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)
 30% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)

Hospital Inpatient Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and
 drugs.....

You Pay

30% Coinsurance after Plan Deductible

Emergency Services

Emergency department visits

You Pay

30% 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

Ambulance Services

You Pay

30% Coinsurance after Plan Deductible

Prescription Drug Coverage

Covered outpatient items in accord with our drug formulary guidelines:

You Pay

30% Coinsurance (not to exceed \$50) for up to a
 100-day supply (Plan Deductible doesn't apply)
 30% Coinsurance (not to exceed \$100) for up to a
 100-day supply (Plan Deductible doesn't apply)
 30% Coinsurance (not to exceed \$250) for up to a
 30-day supply after Plan Deductible

Most generic items (Tier 1) at a Plan Pharmacy or through our mail-
 order service
 Most brand-name items (Tier 2) at a Plan Pharmacy or through our
 mail-order service
 Most specialty items (Tier 4) at a Plan Pharmacy

Durable Medical Equipment (DME)

DME items as described in the EOC

You Pay

30% Coinsurance (Plan Deductible doesn't apply)

Proposed Benefit Summary*(continued)*

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	30% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	30% Coinsurance after Plan Deductible
Group outpatient mental health treatment	30% Coinsurance after Plan Deductible
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	30% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	30% Coinsurance after Plan Deductible
Group outpatient substance use disorder treatment	30% Coinsurance after Plan Deductible
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	30% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i>	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*.