

**Proposed Benefit Summary**

**Benefit Plan 19529**

**\$4,000 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.

<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	\$7,000	\$7,000	\$14,000
Plan Deductible	\$4,000	\$4,000	\$8,000
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**

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 .....

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

**Durable Medical Equipment (DME)**

DME items as described in the EOC .....

**You Pay**

30% Coinsurance (Plan Deductible doesn't apply)

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**Proposed Benefit Summary***(continued)*

<b>Mental Health Services</b>	<b>You Pay</b>
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
<b>Substance Use Disorder Treatment</b>	<b>You Pay</b>
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
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per Accumulation Period) .....	No charge (Plan Deductible doesn't apply)
<b>Other</b>	<b>You Pay</b>
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*.