

Proposed Benefit Summary**Benefit Plan 19433****\$250 DED, \$20/\$30 OV, 10% IP, \$10/\$30/20% 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	\$3,000	\$3,000	\$6,000
Plan Deductible	\$250	\$250	\$500
Drug Deductible	None	None	None

Plan Provider Office Visits

Most Primary Care Visits and most Non-Physician Specialist Visits	\$20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	\$30 per visit (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)
Routine eye exams with a Plan Optometrist.....	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	\$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	\$20 per visit (Plan Deductible doesn't apply)

You Pay**Telehealth Visits**

Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)

You Pay**Outpatient Services**

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	\$15 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the EOC.....	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	10% Coinsurance up to a maximum of \$150 per procedure (Plan Deductible doesn't apply)

You Pay**Hospital Inpatient Services**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	10% Coinsurance after Plan Deductible
---	---------------------------------------

You Pay**Emergency Services**

Emergency department visits	10% Coinsurance after Plan Deductible
-----------------------------------	---------------------------------------

You Pay

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	\$150 per trip (Plan Deductible doesn't apply)
--------------------------	--

You Pay**Prescription Drug Coverage**

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 (Plan Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service	\$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy	\$30 for up to a 30-day supply (Plan Deductible doesn't apply)

You Pay

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 (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed \$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)
--	---

Mental Health Services**You Pay**

Inpatient psychiatric hospitalization	10% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	\$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	\$10 per visit (Plan Deductible doesn't apply)

Substance Use Disorder Treatment**You Pay**

Inpatient detoxification	10% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	\$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	\$5 per visit (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)
---	---

Other**You Pay**

Skilled nursing facility care (up to 100 days per benefit period)	10% Coinsurance (Plan Deductible doesn't apply)
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*.