

Proposed Benefit Summary**Benefit Plan 14670****\$3,500 DED, \$30/\$50 OV, 30% IP, \$15/\$35/30% RX****Principal Benefits for****Kaiser Permanente HSA-Qualified High Deductible Health Plan (“HDHP”) HMO (1/1/26—12/31/26)**

“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	\$6,000	\$6,000	\$12,000
Plan Deductible	\$3,500	\$3,500	\$7,000
Drug Deductible	Not applicable	Not applicable	Not applicable

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 per visit after Plan Deductible
 \$50 per visit 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 per visit after Plan Deductible
 \$30 per visit 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 after Plan Deductible
 No charge after Plan Deductible

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*.....
 MRI, most CT, and PET scans

You Pay

30% Coinsurance after Plan Deductible
 No charge (Plan Deductible doesn't apply)
 \$10 per encounter after Plan Deductible
 No charge (Plan Deductible doesn't apply)
 30% Coinsurance after Plan Deductible

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 \$15 for up to a 30-day supply after Plan Deductible
 Most generic (Tier 1) refills through our mail-order service \$30 for up to a 100-day supply after Plan
 Deductible
 Most brand-name items (Tier 2) at a Plan Pharmacy \$35 for up to a 30-day supply after Plan Deductible

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

Most brand-name (Tier 2) refills through our mail-order service	\$70 for up to a 100-day supply after Plan Deductible
Most specialty items (Tier 4) at a Plan Pharmacy	30% Coinsurance (not to exceed \$250) for up to a 30-day supply after Plan Deductible

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

DME items as described in the <i>EOC</i>	30% Coinsurance after Plan Deductible
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Mental Health Services**You Pay**

Inpatient psychiatric hospitalization	30% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	\$30 per visit after Plan Deductible
Group outpatient mental health treatment	\$15 per visit 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 per visit after Plan Deductible
Group outpatient substance use disorder treatment	\$5 per visit after Plan Deductible

Home Health Services**You Pay**

Home health care (up to 100 visits per Accumulation Period)	No charge after Plan Deductible
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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 after Plan Deductible

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*.