

Proposed Benefit Summary**Benefit Plan 19540****\$3,000 DED, \$0 OV, \$0 IP, \$0/ \$50/ \$250 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	\$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

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

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.....
 Most laboratory tests
 Preventive X-rays, screenings, and laboratory tests as described in
 the EOC.....
 MRI, most CT, and PET scans

You Pay

No charge after Plan Deductible
 No charge (Plan Deductible doesn't apply)
 \$50 per encounter (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)
 No charge (Plan Deductible doesn't apply)
 \$500 per procedure (Plan Deductible doesn't
 apply)

Hospital Inpatient Services

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

You Pay

No charge after Plan Deductible

Emergency Services

Emergency department visits

You Pay

\$500 per visit (Plan Deductible doesn't apply)

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

\$500 per trip (Plan Deductible doesn't apply)

Prescription Drug Coverage

Covered outpatient items in accord with our drug formulary guidelines:

You Pay

No charge for up to a 100-day supply (Plan
 Deductible doesn't apply)
 \$50 for up to a 30-day supply (Plan Deductible
 doesn't apply)

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

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

Most brand-name (Tier 2) refills through our mail-order service	\$100 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>	50% 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)

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*.