**Family Coverage** 

## **Proposed Benefit Summary**

Benefit Plan 14615 \$30/\$40 OV, \$500 DAY-3, \$250 ER, \$15/\$35/30% RX

## Principal Benefits for Kaiser Permanente Traditional HMO Plan (1/1/25—12/31/25)

## **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.

**Self-Only Coverage** 

Family Coverage

Plan Out-of-Pocket Maximum	Amounts Per Accumulation Period	(a Family of one Member)	Each Member in a Family	Entire Family of two or	
Plan   Deductible   None   None   None   None   None   None   None   Drug Deductible   None	Plan Out of Pocket Maximum	,			
Drug Deductible		• ,			
Plan Provider Office Visits  Most Physician Specialist Visits  Routine physical maintenance exams, including well-woman exams.  Well-child preventive exams (through age 23 months)  No charge  Well-child preventive exams (through age 23 months)  No charge  Primary Care Visits and Non-Physician Specialist Visits by interactive video  No charge  Physician Specialist Visits by interactive video  No charge  No c					
Most Primary Care Visits and most Non-Physician Specialist Visits.   \$30 per visit   \$40 per per visit   \$40 per per visit   \$40 per per per visit   \$40 per					
Most Physician Specialist Visits Routine physical maintenance exams, including well-woman exams. No charge Well-child preventive exams (through age 23 months). No charge Well-child preventive exams (through age 23 months). No charge No charge No charge Urgent care consultations, evaluations, and treatment. S30 per visit Wost physical, occupational, and speech therapy. S30 per visit Wost physical, occupational, and speech therapy.  Frimary Care Visits and Non-Physician Specialist Visits by interactive video Physician Specialist Visits by interactive video Physician Specialist Visits by interactive video Physician Specialist Visits by telephone. No charge Physician Specialist Visits by telephone. No charge No charge Outpatient Services  Outpatient Services  Outpatient Surgery and certain other outpatient procedures Most immunizations (including the vaccine). No charge Most X-rays and laboratory tests. S10 per encounter Preventive X-rays, screenings, and laboratory tests as described in the EOC. MRI, most CT, and PET scans. Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  Emergency Services  Emergency Services  Emergency department visits 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  Most generic (Tier 1) at a Plan Pharmacy.  Most generic (Tier 1) teffills through our mail-order service.  Most brand-name items (Tier 2) at a Plan Pharmacy.  Most speciality lems (Tier 4) at a Plan Pharmacy.  Most speciality lems (Tier 4) at a Plan Pharmacy.  Most speciality lems (Tier 4) at a Plan Pharmacy.  Most speciality lems (Tier 4) at a Plan Pharmacy.  Most speciality lems (Tier					
Well-child preventive exams (through age 23 months).  Scheduled prenatal care exams.  No charge No charge No charge Vrgent care consultations, evaluations, and treatment.  S30 per visit Most physical, occupational, and speech therapy.  Primary Care Visits and Non-Physician Specialist Visits by interactive video.  Physician Specialist Visits by interactive video.  No charge Physician Specialist Visits by interactive video.  No charge Primary Care Visits and Non-Physician Specialist Visits by telephone. Physician Specialist Visits by interactive video.  No charge Primary Care Visits and Non-Physician Specialist Visits by telephone. Physician Specialist Visits by telephone. No charge Primary Care Visits and Non-Physician Specialist Visits by telephone. Physician Specialist Visits by telephone. No charge Volupatient Services  Vou Pay  Outpatient surgery and certain other outpatient procedures. Most Immunizations (including the vaccine). No charge Most X-rays and laboratory tests.  S10 per encounter  Preventive X-rays, screenings, and laboratory tests as described in the EOC.  No charge MRI, most CT, and PET scans.  Hospital Inpatient Services  Wou Pay  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  Emergency department visits.  S250 per visit  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 instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient	Most Physician Specialist Visits	\$40 per visit			
Scheduled prenatal care exams					
Routine eye exams with a Plan Optometrist					
Urgent care consultations, evaluations, and treatment					
Most physical, occupational, and speech therapy	Urgent care consultations evaluations	No cnarge	NO Charge		
Telehoalth Visits Primary Care Visits and Non-Physician Specialist Visits by interactive video					
Primary Care Visits and Non-Physician Specialist Visits by interactive video		·			
video					
Physician Specialist Visits by interactive video	<del>-</del>				
Physician Specialist Visits by telephone					
Outpatient Services       You Pay         Outpatient surgery and certain other outpatient procedures       \$250 per procedure         Most immunizations (including the vaccine)       No charge         Most X-rays and laboratory tests       \$10 per encounter         Preventive X-rays, screenings, and laboratory tests as described in the EOC       No charge         MRI, most CT, and PET scans       \$100 per procedure         Hospital Inpatient Services       You Pay         Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs       \$500 per day up to a maximum of \$1,500 per admission         Emergency Services       You Pay         Emergency department visits       \$250 per visit         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       You Pay         Ambulance Services       \$150 per trip         Prescription Drug Coverage       You Pay         Covered outpatient items in accord with our drug formulary guidelines:         Most generic items (Tier 1) at a Plan Pharmacy       \$15 for up to a 30-day supply         Most brand-name items (Tier 2) at a Plan Pharmacy       \$30 for up to a 30-day supply         Most brand-name items (Tier 2) at a Plan Pharmacy       \$70 for up to a 100-day supply			ne No charge	No charge	
Outpatient surgery and certain other outpatient procedures	Physician Specialist Visits by telephone		No charge		
Most immunizations (including the vaccine)					
Most X-rays and laboratory tests					
Preventive X-rays, screenings, and laboratory tests as described in the EOC					
the EOC					
Hospital Inpatient Services  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs					
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs					
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs		• •			
drugs	Room and board, surgery, anesthesia, X-rays, laboratory tests, and		\$500 per day up to a m	aximum of \$1,500 per	
Emergency department visits \$250 per visit  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 You Pay  Ambulance Services \$150 per trip  Prescription Drug Coverage You Pay  Covered outpatient items in accord with our drug formulary guidelines:  Most generic items (Tier 1) at a Plan Pharmacy \$15 for up to a 30-day supply  Most brand-name items (Tier 2) at a Plan Pharmacy \$30 for up to a 100-day supply  Most brand-name (Tier 2) refills through our mail-order service \$70 for up to a 100-day supply  Most specialty items (Tier 4) at a Plan Pharmacy 30% Coinsurance (not to exceed \$250) for up to a					
Emergency department visits					
instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)  Ambulance Services  Ambulance Services  Ambulance Services  Ambulance Services  Ambulance Services  State  You Pay  You Pay  You Pay  Covered outpatient items in accord with our drug formulary guidelines:  Most generic items (Tier 1) at a Plan Pharmacy  Most generic (Tier 1) refills through our mail-order service  Most brand-name items (Tier 2) at a Plan Pharmacy  Most brand-name (Tier 2) refills through our mail-order service  Most specialty items (Tier 4) at a Plan Pharmacy  Most specialty items (Tier 4) at a Plan Pharmacy  30% Coinsurance (not to exceed \$250) for up to a	Emergency department visits				
Ambulance ServicesYou PayAmbulance Services\$150 per tripPrescription Drug CoverageYou PayCovered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy\$15 for up to a 30-day supplyMost generic (Tier 1) refills through our mail-order service\$30 for up to a 100-day supplyMost brand-name items (Tier 2) at a Plan Pharmacy\$35 for up to a 30-day supplyMost brand-name (Tier 2) refills through our mail-order service\$70 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy30% Coinsurance (not to exceed \$250) for up to a					
Ambulance Services		Cost Share (see "Hospital In	•	nt Cost Share)	
Prescription Drug Coverage  Covered outpatient items in accord with our drug formulary guidelines:  Most generic items (Tier 1) at a Plan Pharmacy					
Covered outpatient items in accord with our drug formulary guidelines:  Most generic items (Tier 1) at a Plan Pharmacy					
Most generic items (Tier 1) at a Plan Pharmacy	Covered outsetiest items in accordability		You Pay		
Most generic (Tier 1) refills through our mail-order service				supply	
Most brand-name items (Tier 2) at a Plan Pharmacy					
Most brand-name (Tier 2) refills through our mail-order service					
Most specialty items (Tier 4) at a Plan Pharmacy					
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Proposed Benefit Summary	(continued)	
Durable Medical Equipment (DME)	You Pay	
DME items as described in the EOC	50% Coinsurance	
Mental Health Services	You Pay	
Inpatient psychiatric hospitalization		
Individual outpatient mental health evaluation and treatment  Group outpatient mental health treatment		
Substance Use Disorder Treatment	You Pay	
Inpatient detoxification	\$500 per day up to a maximum of \$1,500 per admission	
Individual outpatient substance use disorder evaluation and treatment	\$30 per visit	
Group outpatient substance use disorder treatment		
Home Health Services	You Pay	
Home health care (up to 100 visits per Accumulation Period)	No charge	
Other	You Pay	
Skilled nursing facility care (up to 100 days per benefit period)		
Prosthetic and orthotic devices as described in the EOC	No charge	
Diagnosis and treatment of infertility and artificial insemination (such		
as outpatient procedures or laboratory tests) as described in the EOC	50% Coinsurance	
Assisted reproductive technology ("ART") Services		
Hospice care		

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*.