

**Proposed Benefit Summary**

**Benefit Plan 14606**

**\$30/\$40 OV, \$250 DAY-3, \$200 ER, \$10/\$30/20% 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.

<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	\$3,000	\$3,000	\$6,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

**Plan Provider Office Visits**

Most Primary Care Visits and most Non-Physician Specialist Visits .....	<b>You Pay</b> \$30 per visit
Most Physician Specialist Visits .....	\$40 per visit
Routine physical maintenance exams, including well-woman exams ....	No charge
Well-child preventive exams (through age 23 months) .....	No charge
Scheduled prenatal care exams .....	No charge
Routine eye exams with a Plan Optometrist.....	No charge
Urgent care consultations, evaluations, and treatment .....	\$30 per visit
Most physical, occupational, and speech therapy .....	\$30 per visit

**Telehealth Visits**

Primary Care Visits and Non-Physician Specialist Visits by interactive video .....	<b>You Pay</b> No charge
Physician Specialist Visits by interactive video .....	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone..	No charge
Physician Specialist Visits by telephone.....	No charge

**Outpatient Services**

Outpatient surgery and certain other outpatient procedures .....	<b>You Pay</b> \$125 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**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	<b>You Pay</b> \$250 per day up to a maximum of \$750 per admission
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**Emergency Services**

Emergency department visits .....	<b>You Pay</b> \$200 per visit
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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 .....	<b>You Pay</b> \$100 per trip
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**Prescription Drug Coverage**

Covered outpatient items in accord with our drug formulary guidelines:	<b>You Pay</b>
Most generic items (Tier 1) at a Plan Pharmacy .....	\$10 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service .....	\$20 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy .....	\$30 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service .....	\$60 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy .....	20% Coinsurance (not to exceed \$250) for up to a 30-day supply

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

<b>Durable Medical Equipment (DME)</b>	<b>You Pay</b>
DME items as described in the <i>EOC</i> .....	50% Coinsurance
<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization .....	\$250 per day up to a maximum of \$750 per admission
Individual outpatient mental health evaluation and treatment .....	\$30 per visit
Group outpatient mental health treatment .....	\$15 per visit
<b>Substance Use Disorder Treatment</b>	<b>You Pay</b>
Inpatient detoxification .....	\$250 per day up to a maximum of \$750 per admission
Individual outpatient substance use disorder evaluation and treatment .....	\$30 per visit
Group outpatient substance use disorder treatment .....	\$5 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per Accumulation Period) .....	No charge
<b>Other</b>	<b>You Pay</b>
Skilled nursing facility care (up to 100 days per benefit period) .....	No charge
Prosthetic and orthotic devices as described in the <i>EOC</i> .....	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i> .....	50% Coinsurance
Assisted reproductive technology ("ART") Services .....	Not covered
Hospice care .....	No charge

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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*.