1/1/25 – 12/31/25
STATE OF CALIFORNIA

Kaiser Permanente Summary of Benefits Traditional HMO Plan

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 or the Drug 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.			
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	$1,500	$1,500	$3,000
Drug Out-of-Pocket Maximum	$7,700	$7,700	$15,400
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 per visit
Most Physician Specialist Visits	$15 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, doula, and postpartum follow-up visits:	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit
Telehealth Visits	**You Pay**
Primary Care Visits and Non-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	No charge
Physician Specialist Visits by telephone	No charge
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit (does not apply if you are held for observation in a hospital unit outside the Emergency Department or if you are admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drugs	**You Pay**
Most generic items (Tier 1) at a Plan Pharmacy	$5 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service	$10 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy	$20 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	$40 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	$20 for up to a 30-day supply
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the EOC	No charge

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Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$15 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care	No charge
Other	**You Pay**
Hearing aids to prevent or treat speech and language developmental delay due to hearing loss every 36 months	No charge
Hearing aids when not to prevent or treat speech and language developmental delay due to hearing loss every 36 months	Amount in excess of $1,000 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
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	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).