

Proposed Benefit Summary**9717 THE SEGAL COMPANY****Principal Benefits for
Kaiser Permanente Traditional 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.

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
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits

Most Primary Care Visits and most Non-Physician Specialist Visits.....	You Pay \$25 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
Routine eye exams with a Plan Optometrist.....	No charge
Urgent care consultations, evaluations, and treatment	\$25 per visit
Most physical, occupational, and speech therapy.....	\$25 per visit

Telehealth Visits

Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	You Pay No charge
Physician Specialist Visits by interactive video or telephone	No charge

Outpatient Services

Outpatient surgery and certain other outpatient procedures	You Pay \$100 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	\$50 per procedure

Hospital Inpatient Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	You Pay \$500 per admission
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Emergency Services

Emergency department visits	You Pay \$100 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	You Pay \$100 per trip
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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
Most generic (Tier 1) refills through our mail-order service	\$30 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy.....	\$35 for up to a 30-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 \$150) for up to a 30-day supply

Durable Medical Equipment (DME)

DME items as described in the EOC.....	You Pay 20% Coinsurance
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Mental Health Services

Inpatient psychiatric hospitalization	You Pay \$500 per admission
Individual outpatient mental health evaluation and treatment	\$25 per visit

Proposed Benefit Summary*(continued)***Mental Health Services**

	You Pay
Group outpatient mental health treatment	\$12 per visit

Substance Use Disorder Treatment

	You Pay
Inpatient detoxification	\$500 per admission

Individual outpatient substance use disorder evaluation and treatment	\$25 per visit
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Group outpatient substance use disorder treatment	\$5 per visit
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Home Health Services

	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge

Other

Skilled nursing facility care (up to 100 days per benefit period)	No charge
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Prosthetic and orthotic devices as described in the EOC	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*.