

Benefits	2025	2026
Annual deductible	\$0	\$0
Annual out-of-pocket maximum (individual/family)	\$2,000/\$4,000	\$2,000/\$4,000
Office visit — primary care physician	\$20 copay	\$20 copay
Office visit — specialist	\$40 copay	\$40 copay
Routine physical exams	\$0 copay	\$0 copay
Diagnostic imaging	\$0 copay for lab and X-ray	\$0 copay for lab and X-ray
Specialty imaging (PET Scans, MRI, etc.)	\$75 copay	\$75 copay
Urgent care	\$20 copay	\$20 copay
Inpatient hospitalization	\$150 copay	\$150 copay
Outpatient surgery at surgery center	\$75 copay	\$75 copay
Emergency visits	\$250 copay	\$250 copay
Ambulance	\$75 copay	\$75 copay
Inpatient mental health	\$150 copay	\$150 copay
Outpatient mental health (individual visit/group visit)	\$20/\$10 copay	\$20/\$10 copay
Inpatient chemical dependency	\$150 copay	\$150 copay
Outpatient chemical dependency (individual visit/group visit)	\$20/\$10 copay	\$20/\$10 copay
Physical, occupational, and speech therapy	\$40 copay, limited to 60 visits per injury, incident, or condition for each therapy	\$40 copay, limited to 60 visits per injury, incident, or condition for each therapy
Autism spectrum disorder (ASD) (services for medically necessary treatment and diagnosis)	Benefits available for an individual of any age	Benefits available for an individual of any age
Durable medical equipment	10% coinsurance	10% coinsurance
Vision allowance for prescription glasses or contact lenses	\$150/year	\$150/year
Vision discount for frames and lenses (prescription only)	25% discount	25% discount
Vision discount for prescription contact lenses & initial fitting	15% discount	15% discount
Hearing aids	10% coinsurance, 1 hearing aid/ear/36 months, \$1,500 benefit maximum	10% coinsurance: Adults: \$1,000 limit/ear/36 months; Children: \$1,500 limit/ear/24 months
Prescription coverage	2025	2026
Filled through mail order:¹ Up to a 90-day supply, 1 copay	\$10 copay most generic drugs (Tier 1) \$20 copay most preferred drugs (Tier 2) \$35 copay non-preferred drugs (Tier 3)	\$10 copay most generic drugs (Tier 1) \$20 copay most preferred drugs (Tier 2) \$35 copay non-preferred drugs (Tier 3)
Filled at Kaiser Permanente medical center pharmacy: Up to a 60-day supply, 1 copay Up to a 90-day supply, 1.5 copays	\$10 copay most generic drugs (Tier 1) \$20 copay most preferred drugs (Tier 2) \$35 copay non-preferred drugs (Tier 3)	\$10 copay most generic drugs (Tier 1) \$20 copay most preferred drugs (Tier 2) \$35 copay non-preferred drugs (Tier 3)
Filled at participating community network pharmacy: Up to a 60-day supply, 1 copay Up to a 90-day supply, 1.5 copays	\$30 copay most generic drugs (Tier 1) \$50 copay most preferred drugs (Tier 2) \$75 copay non-preferred drugs (Tier 3)	\$30 copay most generic drugs (Tier 1) \$50 copay most preferred drugs (Tier 2) \$75 copay non-preferred drugs (Tier 3)

For specific information about your health plan benefits, including a full list of exclusions and limitations, please see your *Evidence of Coverage*.

¹Some medications are not eligible for Mail Order Pharmacy. Mail Order Pharmacy can deliver to addresses in MD, VA, DC, and certain locations outside the service area.