

Disclosure Form Part One

7922 S.F. SOCIETY PREVENT. OF CRUELTY TO ANIMALS

Home Region: Northern California

1/1/27 through 12/31/27

Principal benefits for Kaiser Permanente 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, 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	\$2,500	\$2,500	\$5,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits

You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits	\$20 per visit
Most Physician Specialist Visits	\$20 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (up to and including 23 months)	No charge
Routine eye exams with a Plan Optometrist	No charge
Most urgent care consultations, evaluations, and treatment	\$20 per visit
Most physical, occupational, and speech therapy	\$20 per visit

Telehealth Visits

You Pay

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

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	\$50 per procedure

Hospital Inpatient Services

You Pay

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

You Pay

Emergency department visits	\$200 per visit
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Note: If you are admitted directly to the hospital as an inpatient for Covered Benefits, 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	\$100 per trip
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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 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 \$250) for up to a 30-day supply

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Durable Medical Equipment (DME)

You Pay

DME items as described in the *EOC*..... 20% Coinsurance

Mental Health Services

You Pay

Inpatient psychiatric hospitalization..... \$500 per admission

Individual outpatient mental health evaluation and treatment \$20 per visit

Group outpatient mental health treatment..... \$10 per visit

Substance Use Disorder Treatment

You Pay

Inpatient detoxification..... \$500 per admission

Individual outpatient substance use disorder evaluation and treatment \$20 per visit

Group outpatient substance use disorder treatment \$5 per visit

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)..... No charge

Prosthetic and orthotic devices as described in the *EOC* No charge

Fertility Services, such as outpatient procedures or laboratory tests,
as described in the *EOC* (see *EOC* for benefit limits)..... The Cost Share you would pay if the services were
to treat any other condition

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*.

Disclosure Form Part Two

The *Disclosure Form Part Two* provides an overview of important features of your Health Plan membership, including how to obtain Covered Benefits, principal exclusions, and important notices. To view or download a copy, go to kp.org/choosekp or call Member Services at 1-800-464-4000 (TTY users call 711).