

Disclosure Form Part One

702476 ADDEPAR INC

Home Region: Northern California

1/1/25 through 12/31/25

Principal benefits for Kaiser Permanente Multi-State 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	\$1,750	\$1,750	\$3,500
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.....	\$15 per visit
Most Physician Specialist Visits	\$25 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	\$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 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	\$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	\$75 per procedure

Hospital Inpatient Services

	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$250 per admission

Emergency Services

	You Pay
Emergency department visits	\$200 per visit
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

	You Pay
Ambulance Services	\$100 per trip

Prescription Drug Coverage

	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
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

Durable Medical Equipment (DME)

	You Pay
DME items as described in the EOC	20% Coinsurance

Mental Health Services

	You Pay
Inpatient psychiatric hospitalization	\$250 per admission

(continues)

Disclosure Form Part One*(continued)***Mental Health Services****You Pay**

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.....	\$250 per admission
Individual outpatient substance use disorder evaluation and treatment	\$15 per visit
Group outpatient substance use disorder treatment	\$7 per visit

Home Health Services**You Pay**

Home health care (up to 120 visits per Accumulation Period)	No charge
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Other**You Pay**

Hearing aids every 36 months.....	Amount in excess of \$1,000 Allowance for each ear
Skilled nursing facility care (up to 100 days per benefit period)	\$250 per admission
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>	10% Coinsurance
Assisted reproductive technology ("ART") Services (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i> (one treatment cycle lifetime maximum)	10% Coinsurance

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 Services, 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).