### **Disclosure Form Part One**

233715 ASCIP-RANCHO SANTIAGO CCD

Home Region: Southern California

1/1/25 through 12/31/25

# 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   (a Family of one Member)   Each Member in a Family of two or more Members   Plan Out-of-Pocket Maximum   \$1,500   \$1,500   \$3,000   \$3,000   \$1,500   \$0,000		Self-Only Coverage	Family Coverage	Family Coverage	
Plan Out-of-Pocket Maximum \$1,500 \$1,500 \$3,000 Plan Deductible None None None None Drug Deductible None None None None Plan Provider Office Visits None None None None Plan Provider Office Visits Symost Primary Care Visits and most Non-Physician Specialist Visits Symost Physician Specialist Visits Symost Physician Specialist Visits Symost Physician Specialist Visits Symost Physician Specialist Visits Symost Primary Care Visits and most Non-Physician Specialist Visits Symost Physician Specialist Visits Symost Symostra Sy	Amounts Per Accumulation Period		Each Member in a Family	Entire Family of two or	
Plan Deductible   None   None   None   None   None   Drug Deductible   None   None   None   None   None   None   Plan Provider Office Visits   You Pay		, , ,			
Drug Deductible   None   None   None   None   None   Plan Provider Office Visits					
Plan Provider Office Visits   You Pay					
Most Primary Care Visits and most Non-Physician Specialist Visits   \$10 per visit   Nost Physician Specialist Visits   \$10 per visit   \$10 per procedure   \$10 p		None		none	
Most Physician Specialist Visits					
Routine physical maintenance exams, including well-woman exams No charge Well-child preventive exams (through age 23 months)					
Well-child preventive exams (through age 23 months)	Most Physician Specialist Visits		\$10 per visit		
Routine eye exams with a Plan Optometrist					
Urgent caire consultations, evaluations, and treatment.  Most physical, occupational, and speech therapy.  Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone. Physician Specialist Visits by interactive video or telephone. No charge Physician Specialist Visits by interactive video or telephone. No charge  Outpatient Services  Outpatient Surgery and certain other outpatient procedures. Most immunizations (including the vaccine). Most Arays and laboratory tests. Most Arays and laboratory tests. Most Arays and laboratory tests.  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  Emergency Services  Emergency Gepartment visits. 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," our will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services," for inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services," our will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services," you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services," you Pay  Ambulance Services.  Prescription Drug Coverage  Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service.  Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service.  Most brand-name items (Tier 4) at a Plan Pharmacy or through our mail-order service.  Most brand-name items (Tier 4) at a Plan Pharmacy or through our mail-order service.  Most brand-name items (Tier 4) at a Plan Pharmacy or through our mail-order service.  No charge  Proud Pay  No charge  You Pay  No charge  You Pay  No charge  You Pay  No charge  First 1 of 1 or up to					
Most physical, occupational, and speech therapy					
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         \$10 per procedure           Most immunizations (including the vaccine)         No charge           Most X-rays and laboratory tests         No charge           Hospital Inpatient Services         You Pay           Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs         No charge           Emergency Services         You Pay           Emergency department visits         \$35 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           Prescription Drug Coverage         You Pay           Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy or through our mailorder service.         \$5 for up to a 100-day supply           Most brand-name items (Tier 2) at a Plan Pharmacy or through our mailorder service.         \$10 for up to a 30-day supply					
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone					
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.       \$10 per procedure         Most X-rays and laboratory tests.       No charge         Hospital Inpatient Services       You Pay         Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.       No charge         Emergency Services       You Pay         Emergency department visits.       \$35 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.       You Pay         Covered outpatient items in accord with our drug formulary guidelines:       Story and a process of the service of			ve rour dy		
Physician Specialist Visits by interactive video or telephone.  Outpatient Services  Outpatient surgery and certain other outpatient procedures.  So per procedure  Most immunizations (including the vaccine)	video or telephone		No charge		
Outpatient Services         You Pay           Outpatient surgery and certain other outpatient procedures         \$10 per procedure           Most immunizations (including the vaccine)         No charge           Most X-rays and laboratory tests         No charge           Hospital Inpatient Services         You Pay           Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs         No charge           Emergency Services         You Pay           Emergency department visits         \$35 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         No charge           Prescription Drug Coverage         You Pay           Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service.         \$5 for up to a 100-day supply           Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service.         \$10 for up to a 30-day supply           Most specialty items (Tier 4) at a Plan Pharmacy         \$10 for up to a 30-day supply           Durable Medical Equipment (DME)         You Pay           DME items as described in the EOC.         No charg					
Most immunizations (including the vaccine)			· ·		
Most X-rays and laboratory tests					
Hospital Inpatient Services   You Pay	Most immunizations (including the vaccine)				
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	Most X-rays and laboratory tests		No charge	No charge	
Emergency Services				You Pay	
Emergency Services \$\frac{\text{You Pay}}{\text{\$35 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 \$\frac{\text{You Pay}}{\text{Ambulance Services.}}\$  Ambulance Services.  Prescription Drug Coverage  Covered outpatient items in accord with our drug formulary guidelines.  Most generic items (Tier 1) at a Plan Pharmacy or through our mailorder service.  Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service.  Most specialty items (Tier 4) at a Plan Pharmacy or through our mail-order service.  Durable Medical Equipment (DME)  DME items as described in the EOC.  Mo charge  Mental Health Services  No charge  Inpatient psychiatric hospitalization.  Inpatient psychiatric hospitalization.  No charge  Individual outpatient mental health evaluation and treatment.  \$5 per visit  Substance Use Disorder Treatment  You Pay					
Emergency department visits	-				
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  Ambulance Services  Ambulance Services  Ambulance Services  No charge  Prescription Drug Coverage  Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy or through our mailorder service  Most brand-name items (Tier 2) at a Plan Pharmacy or through our mailorder service  Most specialty items (Tier 4) at a Plan Pharmacy  Most specialty items (Tier 4) at a Plan Pharmacy  Durable Medical Equipment (DME)  DME items as described in the EOC  Mental Health Services  Inpatient psychiatric hospitalization  Inpatient psychiatric hospitalization  Individual outpatient mental health evaluation and treatment  Substance Use Disorder Treatment  You Pay  You Pay  You Pay  No charge  \$10 per visit  \$5 per visit  \$5 per visit  \$5 per visit  You Pay					
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Prescription Drug Coverage  Covered outpatient items in accord with our drug formulary guidelines:  Most generic items (Tier 1) at a Plan Pharmacy or through our mailorder service					
Covered outpatient items in accord with our drug formulary guidelines:  Most generic items (Tier 1) at a Plan Pharmacy or through our mail- order service			ŭ		
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Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service				\$5 for up to a 100-day supply	
mail-order service				зарріу	
Most specialty items (Tier 4) at a Plan Pharmacy \$10 for up to a 30-day supply  Durable Medical Equipment (DME)  DME items as described in the EOC No charge  Mental Health Services  Inpatient psychiatric hospitalization No charge Individual outpatient mental health evaluation and treatment \$10 per visit  Group outpatient mental health treatment \$5 per visit  Substance Use Disorder Treatment  You Pay				supply	
DME items as described in the EOC					
DME items as described in the EOC	Durable Medical Equipment (DME)				
Inpatient psychiatric hospitalization	DME items as described in the EOC		No charge		
Individual outpatient mental health evaluation and treatment	Mental Health Services		You Pay		
Individual outpatient mental health evaluation and treatment	Inpatient psychiatric hospitalization		No charge		
Substance Use Disorder Treatment You Pay	Individual outpatient mental health evaluation and treatment		\$10 per visit		
			\$5 per visit		
	<b>Substance Use Disorder Treatment</b>				

Disclosure Form Part One	(continued)
Substance Use Disorder Treatment	You Pay
Individual outpatient substance use disorder evaluation and treatment Group outpatient substance use disorder treatment	\$10 per visit \$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	You Pay
Hearing aids every 36 months	Amount in excess of \$2,000 Allowance for each ear
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the EOC	No charge
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the EOC	the Cost Share you would pay if the Services were to treat any other condition
Assisted reproductive technology ("ART") Services	Not covered

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 <a href="kp.org/choosekp">kp.org/choosekp</a> or call Member Services at 1-800-464-4000 (TTY users call 711).