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**Disclosure Form Part One**

100136 COUNTY OF SAN BERNARDINO  
Home Region: Southern California  
7/25/26 through 7/23/27

**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.

<b>Amounts Per Accumulation Period</b>	<b>Self-Only Coverage</b> (a Family of one Member)	<b>Family Coverage</b> Each Member in a Family of two or more Members	<b>Family Coverage</b> Entire Family of two or more Members
Plan Out-of-Pocket Maximum	\$3,000	\$3,000	\$6,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

**Plan Provider Office Visits**

	<b>You Pay</b>
Most Primary Care Visits and most Non-Physician Specialist Visits.....	\$40 per visit
Most Physician Specialist Visits .....	\$50 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 .....	\$40 per visit
Most physical, occupational, and speech therapy .....	\$40 per visit

**Telehealth Visits**

	<b>You Pay</b>
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**

	<b>You Pay</b>
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 .....	\$100 per procedure

**Hospital Inpatient Services**

	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	\$500 per day

**Emergency Services and Care**

	<b>You Pay</b>
Emergency department visits .....	\$150 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**

	<b>You Pay</b>
Ambulance Services.....	\$150 per trip

**Prescription Drug Coverage**

	<b>You Pay</b>
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

**Durable Medical Equipment (DME)**

	<b>You Pay</b>
DME items as described in the EOC.....	50% Coinsurance

**Mental Health Services**

	<b>You Pay</b>
Inpatient psychiatric hospitalization.....	\$500 per day

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**Disclosure Form Part One***(continued)*

<b>Mental Health Services</b>	<b>You Pay</b>
Individual outpatient mental health evaluation and treatment .....	\$40 per visit
Group outpatient mental health treatment.....	\$20 per visit
<b>Substance Use Disorder Treatment</b>	<b>You Pay</b>
Inpatient detoxification.....	\$500 per day
Individual outpatient substance use disorder evaluation and treatment	\$40 per visit
Group outpatient substance use disorder treatment .....	\$5 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per Accumulation Period) .....	No charge
<b>Other</b>	<b>You Pay</b>
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
Prosthetic and orthotic devices as described in the <i>EOC</i> .....	No charge
Fertility Services (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i> (oocyte retrievals limited to three per lifetime) .....	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*.

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**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](http://kp.org/choosekp) or call Member Services at 1-800-464-4000 (TTY users call 711).