

## 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 Deductible 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.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum 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	\$5,000	\$5,000	\$10,000
Plan Deductible	\$500	\$500	\$1,000
Drug Deductible	None	None	None

### Plan Provider Office Visits

	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits.....	\$30 per visit after Plan Deductible*
Most Physician Specialist Visits .....	\$30 per visit after Plan Deductible
Routine physical maintenance exams, including well-woman exams....	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months) .....	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist .....	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment .....	\$30 per visit after Plan Deductible*
Most physical, occupational, and speech therapy .....	\$30 per visit after Plan Deductible

\*The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the EOC.

### Telehealth Visits

	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone .....	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video or telephone .....	No charge (Plan Deductible doesn't apply)

### Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures .....	20% Coinsurance after Plan Deductible
Most immunizations (including the vaccine).....	No charge (Plan Deductible doesn't apply)
Most X-rays .....	20% Coinsurance after Plan Deductible
Most laboratory tests .....	\$15 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the EOC .....	No charge (Plan Deductible doesn't apply)

### Hospital Inpatient Services

	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	20% Coinsurance after Plan Deductible

### Emergency Services and Care

	You Pay
Emergency department visits .....	20% Coinsurance after Plan Deductible

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.....	20% Coinsurance after Plan Deductible

### 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 (Plan Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service .....	\$30 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy .....	\$30 for up to a 30-day supply after Plan Deductible

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**Disclosure Form Part One***(continued)***Prescription Drug Coverage****You Pay**

Most brand-name (Tier 2) refills through our mail-order service .....	\$60 for up to a 100-day supply after Plan Deductible
Most specialty items (Tier 4) at a Plan Pharmacy .....	20% Coinsurance (not to exceed \$250) for up to a 30-day supply after Plan Deductible

**Durable Medical Equipment (DME)****You Pay**

DME items as described in the <i>EOC</i> .....	20% Coinsurance (Plan Deductible doesn't apply)
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**Mental Health Services****You Pay**

Inpatient psychiatric hospitalization .....	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment .....	\$30 per visit after Plan Deductible*
Group outpatient mental health treatment .....	\$15 per visit after Plan Deductible*

\*The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the *EOC*.

**Substance Use Disorder Treatment****You Pay**

Inpatient detoxification .....	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment .....	\$30 per visit after Plan Deductible*
Group outpatient substance use disorder treatment .....	\$5 per visit after Plan Deductible*

\*The Plan Deductible doesn't apply to your first three visits combined for primary care, urgent care, mental health, and substance use disorder treatment Services as described in the *EOC*.

**Home Health Services****You Pay**

Home health care (up to 100 visits per Accumulation Period) .....	No charge (Plan Deductible doesn't apply)
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**Other****You Pay**

Skilled nursing facility care (up to 100 days per benefit period) .....	20% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i> .....	No charge (Plan Deductible doesn't apply)
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).