Disclosure Form Part One

607520 Sares-Regis Operating Company, LP

Home Region: Northern California

1/1/25 through 12/31/25

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

Amounts Per Accumulation Period

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.

Self-Only Coverage

(a Family of one Member)

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.

Family Coverage

Each Member in a Family

of two or more Members

Family Coverage

Entire Family of two or

more Members

Plan Deductible 91,500 \$1,500 \$3,000 \$3,000 Plan Deductible 91,500 \$1,500 \$3,000 Prug Deductible None None None None None Plan Peductible Stits None None None None Plan Peductible Oscillators (Plan Deductible Oscillators) Provider Office Visits Amost Prinary Care Visits and most Non-Physician Specialist Visits. \$50 per visit (Plan Deductible doesn't apply) Most Physician Specialist Visits (Plan Deductible doesn't apply) Routine physical maintenance exams, including well-woman exams. No charge (Plan Deductible doesn't apply) Routine physical maintenance exams, including well-woman exams. No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$30 per visit (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$30 per visit (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$30 per visit fer Plan Deductible Physician Specialist Visits by interactive video or telephone. No charge (Plan Deductible doesn't apply) Most privation specialist Visits by interactive video or telephone. No charge (Plan Deductible doesn't apply) Outpatient Services Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone. No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient Services You Pay No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests. No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests. No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests. No charge after Plan Deductible doesn't apply) Most Jay and Alboratory tests. No charge after Plan Deductible doesn't apply) Most private and the description of the private Alboratory tests, and drugs. Plan Deductible doesn't apply Note: If you are admitted directly to the hospital as an inpatient for covered		, ,	of two or more Members	more Members	
Drug Deductible			,		
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video or telephone	Telehealth Visits			You Pay	
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drugs			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	Room and board, surgery, anesthesia,		<u> </u>	Plan Deductible	
Ambulance Services	Room and board, surgery, anesthesia, drugs Emergency Services		20% Coinsurance after You Pay		
Prescription Drug Coverage Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy	Room and board, surgery, anesthesia, drugs Emergency Services Emergency department visits	hospital as an inpatient for o	20% Coinsurance after You Pay \$200 per visit (Plan Decovered Services, you will pa	ductible doesn't apply) by the inpatient Cost Share	
Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy	Room and board, surgery, anesthesia, drugs	hospital as an inpatient for o	20% Coinsurance after You Pay \$200 per visit (Plan Decovered Services, you will pan patient Services" for inpatient You Pay	ductible doesn't apply) by the inpatient Cost Share nt Cost Share)	
Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy	Room and board, surgery, anesthesia, drugs	hospital as an inpatient for o	20% Coinsurance after You Pay \$200 per visit (Plan Decovered Services, you will pan patient Services" for inpatient You Pay	ductible doesn't apply) by the inpatient Cost Share nt Cost Share)	
Most generic (Tier 1) refills through our mail-order service	Room and board, surgery, anesthesia, drugs	hospital as an inpatient for o	20% Coinsurance after You Pay \$200 per visit (Plan Decovered Services, you will pan patient Services" for inpatient You Pay \$200 per trip after Plan	ductible doesn't apply) by the inpatient Cost Share nt Cost Share)	
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Disclosure Form Part One	(continued)	
Durable Medical Equipment (DME)	You Pay	
DME items as described in the EOC	20% Coinsurance (Plan Deductible doesn't apply)	
Mental Health Services	You Pay	
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible	
Individual outpatient mental health evaluation and treatment	\$30 per visit (Plan Deductible doesn't apply)	
Group outpatient mental health treatment	\$15 per visit (Plan Deductible doesn't apply)	
Substance Use Disorder Treatment	You Pay	
Inpatient detoxification	20% Coinsurance after Plan Deductible	
Individual outpatient substance use disorder evaluation and treatment	\$30 per visit (Plan Deductible doesn't apply)	
Group outpatient substance use disorder treatment	\$15 per visit (Plan Deductible doesn't apply)	
Home Health Services	You Pay	
Home health care (up to 120 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)	
Other	You Pay	
Hearing aids every 36 months	Amount in excess of \$1,000 Allowance for each	
	ear (Allowance not subject to Plan Deductible)	
Skilled nursing facility care (up to 120 days per calendar year)		
Prosthetic and orthotic devices as described in the EOC	3 (
Diagnosis and treatment of infertility and artificial insemination		
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 kp.org/choosekp or call Member Services at 1-800-464-4000 (TTY users call 711).