Disclosure Form Part One

236383 Health Plan of San Joaquin
Home Region: Southern California
1/1/26 through 12/31/26

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	$1,500	$1,500	$3,000
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	$25 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$40 per visit (Plan Deductible doesn't apply)
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	$25 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$25 per visit after Plan Deductible
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	$250 per procedure after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	No charge after Plan Deductible
Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	10% Coinsurance after Plan Deductible
Emergency Services and Care	**You Pay**
Emergency department visits	$150 per visit (Plan Deductible doesn't apply)

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	$150 per trip 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	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service	$20 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 (Plan Deductible doesn't apply)
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)

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Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	10% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	10% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$25 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$12 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	10% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$25 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	$12 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)	10% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)

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).