

## Disclosure Form Part One

101321 THE INTERPUBLIC GROUP OF COMPANIES

Home Region: Southern 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

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<br>(a Family of one Member) | Family Coverage<br>Each Member in a Family<br>of two or more Members | Family Coverage<br>Entire Family of two or<br>more Members |
|---------------------------------|--|--|--|
| Plan Out-of-Pocket Maximum      | \$3,000  | \$3,000  | \$6,000  |
| Plan Deductible                 | \$500  | \$500  | \$1,000  |
| Drug Deductible                 | \$100  | \$100  | Not applicable   |

### Plan Provider Office Visits

|  |  |
|--|--|
| Most Primary Care Visits and most Non-Physician Specialist Visits..... | <b>You Pay</b><br>\$20 per visit (Plan Deductible doesn't apply) |
| Most Physician Specialist Visits .....                                 | \$20 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 .....            | \$20 per visit (Plan Deductible doesn't apply)                   |
| Most physical, occupational, and speech therapy.....                   | \$20 per visit after Plan Deductible                             |

### Telehealth Visits

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

### Outpatient Services

|   |   |
|---|---|
| Outpatient surgery and certain other outpatient procedures.....                   | <b>You Pay</b><br>20% Coinsurance after Plan Deductible                     |
| Most immunizations (including the vaccine).....                                   | No charge (Plan Deductible doesn't apply)                                   |
| Most X-rays and laboratory tests.....   | \$10 per encounter after Plan Deductible                                    |
| Preventive X-rays, screenings, and laboratory tests as described in the EOC ..... | No charge (Plan Deductible doesn't apply)                                   |
| MRI, most CT, and PET scans.....  | 20% Coinsurance up to a maximum of \$50 per procedure after Plan Deductible |

### Hospital Inpatient Services

|   |   |
|---|---|
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs..... | <b>You Pay</b><br>20% Coinsurance after Plan Deductible |
|---|---|

### Emergency Services

|                                   |   |
|-----------------------------------|---|
| Emergency department visits ..... | <b>You Pay</b><br>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

|                         |  |
|-------------------------|--|
| Ambulance Services..... | <b>You Pay</b><br>\$150 per trip after Plan Deductible |
|-------------------------|--|

### Prescription Drug Coverage

|   |   |
|---|---|
| Covered outpatient items in accord with our drug formulary guidelines:                    | <b>You Pay</b>  |
| Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service.....     | \$10 for up to a 100-day supply (Drug Deductible doesn't apply) |
| Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service ..... | \$30 for up to a 100-day supply after Drug Deductible           |
| Most specialty items (Tier 4) at a Plan Pharmacy .....                                    | \$30 for up to a 30-day supply after Drug Deductible            |

(continues)

---

**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 ..... \$20 per visit (Plan Deductible doesn't apply)  
Group outpatient mental health treatment ..... \$10 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 ..... \$20 per visit (Plan Deductible doesn't apply)  
Group outpatient substance use disorder treatment ..... \$5 per visit (Plan Deductible doesn't apply)**Home Health Services****You Pay**

---

Home health care (up to 100 visits per Accumulation Period) ..... No charge (Plan Deductible doesn't apply)**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 *EOC* ..... No charge (Plan Deductible doesn't apply)  
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC* ..... 50% Coinsurance (Plan Deductible doesn't apply)  
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](http://kp.org/choosekp) or call Member Services at 1-800-464-4000 (TTY users call 711).