

**Disclosure Form Part One**

88131 PRISM - CITY OF MODESTO  
Home Region: Northern California  
1/1/25 through 12/31/25

**Principal benefits for Kaiser Permanente HSA-Qualified High Deductible Health Plan (“HDHP”) HMO**

“Kaiser Permanente HSA-Qualified High Deductible Health Plan (“HDHP”) HMO” is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the EOC.

**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.

<b>Amounts Per Accumulation Period</b>	<b>Self-Only Coverage (a Family of one Member)</b>	<b>Family Coverage Each Member in a Family of two or more Members</b>	<b>Family Coverage Entire Family of two or more Members</b>
Plan Out-of-Pocket Maximum	\$3,300	\$3,300	\$6,600
Plan Deductible	\$3,300	\$3,300	\$6,600
Drug Deductible	Not applicable	Not applicable	Not applicable

**Plan Provider Office Visits**

Most Primary Care Visits and most Non-Physician Specialist Visits .....  
Most Physician Specialist Visits .....  
Routine physical maintenance exams, including well-woman exams ....  
Well-child preventive exams (through age 23 months) .....  
Routine eye exams with a Plan Optometrist .....  
Urgent care consultations, evaluations, and treatment .....  
Most physical, occupational, and speech therapy.....

**You Pay**

No charge after Plan Deductible  
No charge after Plan Deductible  
No charge (Plan Deductible doesn't apply)  
No charge (Plan Deductible doesn't apply)  
No charge (Plan Deductible doesn't apply)  
No charge after Plan Deductible  
No charge after Plan Deductible

**Telehealth Visits**

Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone.....  
Physician Specialist Visits by interactive video or telephone .....

**You Pay**

No charge after Plan Deductible  
No charge after Plan Deductible

**Outpatient Services**

Outpatient surgery and certain other outpatient procedures .....  
Most immunizations (including the vaccine).....  
Most X-rays and laboratory tests.....  
Preventive X-rays, screenings, and laboratory tests as described in the EOC .....

**You Pay**

No charge after Plan Deductible  
No charge (Plan Deductible doesn't apply)  
No charge after Plan Deductible  
No charge (Plan Deductible doesn't apply)

**Hospital Inpatient Services**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....

**You Pay**

No charge after Plan Deductible

**Emergency Services**

Emergency department visits .....

**You Pay**

No charge 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.....

**You Pay**

No charge after Plan Deductible

**Prescription Drug Coverage**

Covered outpatient items in accord with our drug formulary guidelines:

**You Pay**

No charge for up to a 100-day supply after Plan Deductible  
No charge for up to a 100-day supply after Plan Deductible  
No charge for up to a 30-day supply after Plan Deductible

(continues)

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**Disclosure Form Part One***(continued)***Durable Medical Equipment (DME)**

	<b>You Pay</b>
Base DME items as described in the <i>EOC</i> .....	No charge after Plan Deductible
Supplemental DME items up to a \$2,500 benefit limit per Accumulation Period as described in the <i>EOC</i> .....	No charge after Plan Deductible

**Mental Health Services**

	<b>You Pay</b>
Inpatient psychiatric hospitalization.....	No charge after Plan Deductible
Individual outpatient mental health evaluation and treatment.....	No charge after Plan Deductible
Group outpatient mental health treatment.....	No charge after Plan Deductible

**Substance Use Disorder Treatment**

	<b>You Pay</b>
Inpatient detoxification.....	No charge after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment.....	No charge after Plan Deductible
Group outpatient substance use disorder treatment.....	No charge after Plan Deductible

**Home Health Services**

	<b>You Pay</b>
Home health care (up to 100 visits per Accumulation Period).....	No charge after Plan Deductible

**Other**

	<b>You Pay</b>
Skilled nursing facility care (up to 100 days per benefit period).....	No charge after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i> .....	No charge after Plan Deductible
Diagnosis and treatment of infertility and artificial insemination.....	Not covered
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*.

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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).