
Disclosure Form Part One

606031 City of San Jose VEBA
Home Region: Northern California
1/1/25 through 12/31/25

Principal benefits for Kaiser Permanente Traditional 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.

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	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits

Most Primary Care Visits and most Non-Physician Specialist Visits.....	You Pay \$25 per visit
Most Physician Specialist Visits	\$25 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	\$25 per visit
Most physical, occupational, and speech therapy	\$25 per visit

Telehealth Visits

Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone.....	You Pay No charge
Physician Specialist Visits by interactive video or telephone	No charge

Outpatient Services

Outpatient surgery and certain other outpatient procedures	You Pay \$100 per procedure
Most immunizations (including the vaccine).....	No charge
Most X-rays and laboratory tests.....	No charge

Hospital Inpatient Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	You Pay \$100 per admission
--	---------------------------------------

Emergency Services

Emergency department visits	You Pay \$100 per visit
-----------------------------------	-----------------------------------

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
-------------------------	-----------------------------

Prescription Drug Coverage

Covered outpatient items in accord with our drug formulary guidelines:	You Pay
Most generic items (Tier 1) at a Plan Pharmacy	\$10 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service	\$20 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy.....	\$25 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	\$50 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	\$25 for up to a 30-day supply

Durable Medical Equipment (DME)

DME items as described in the EOC.....	You Pay No charge
--	-----------------------------

Mental Health Services

Inpatient psychiatric hospitalization.....	You Pay \$100 per admission
Individual outpatient mental health evaluation and treatment	\$25 per visit
Group outpatient mental health treatment.....	\$12 per visit

Substance Use Disorder Treatment

Inpatient detoxification.....	You Pay \$100 per admission
-------------------------------	---------------------------------------

(continues)

Disclosure Form Part One*(continued)*

Substance Use Disorder Treatment	You Pay
Individual outpatient substance use disorder evaluation and treatment	\$25 per visit
Group outpatient substance use disorder treatment	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	You Pay
Hearing aids every 36 months.....	Amount in excess of \$500 Allowance for each ear
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i>	50% Coinsurance
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).