**Disclosure Form Part One**

100101 RIVERSIDE COMMUNITY COLLEGE DISTRICT
Home Region: Southern California
10/1/25 through 9/30/26

# Principal benefits for Kaiser Permanente Traditional HMO Plan

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call Member Services.

## 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** | **You Pay** |
|---|---|
| Most Primary Care Visits and most Non-Physician Specialist Visits | No charge |
| Most Physician Specialist Visits | No charge |
| 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 | No charge |
| Most physical, occupational, and speech therapy | No charge |
| **Telehealth Visits** | **You Pay** |
| Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone | No charge |
| Physician Specialist Visits by interactive video or telephone | No charge |
| **Outpatient Services** | **You Pay** |
| Outpatient surgery and certain other outpatient procedures | No charge |
| Most immunizations (including the vaccine) | No charge |
| Most X-rays and laboratory tests | No charge |
| **Hospital Inpatient Services** | **You Pay** |
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | No charge |
| **Emergency Services** | **You Pay** |
| Emergency department visits | $35 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** | **You Pay** |
|---|---|
| Ambulance Services | No charge |
| **Prescription Drug Coverage** | **You Pay** |
| Covered outpatient items in accord with our drug formulary guidelines: | |
| Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service | $5 for up to a 100-day supply |
| Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service | $5 for up to a 100-day supply |
| Most specialty items (Tier 4) at a Plan Pharmacy | $5 for up to a 30-day supply |
| **Durable Medical Equipment (DME)** | **You Pay** |
| DME items as described in the *EOC* | No charge |
| **Mental Health Services** | **You Pay** |
| Inpatient psychiatric hospitalization | No charge |
| Individual outpatient mental health evaluation and treatment | No charge |
| Group outpatient mental health treatment | No charge |

*(continues)*

## Disclosure Form Part One

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| Substance Use Disorder Treatment | You Pay |
|---|---|
| Inpatient detoxification | No charge |
| Individual outpatient substance use disorder evaluation and treatment | No charge |
| Group outpatient substance use disorder treatment | No charge |
| **Home Health Services** | **You Pay** |
| Home health care (up to 100 visits per Accumulation Period) | No charge |
| **Other** | **You Pay** |
| Eyeglasses or contact lenses every 24 months | Amount in excess of $100 Allowance |
| Hearing aids every 36 months | Amount in excess of $2,500 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 *EOC* | No charge |

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).