Disclosure Form Part One

235801 AFFIRM INC
Home Region: Southern California
1/1/27 through 12/31/27

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	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 per visit
Most Physician Specialist Visits	$15 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (up to and including 23 months)	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit

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	$100 per procedure
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	$250 per admission

Emergency Services and Care	You Pay
Emergency department visits	$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	You Pay
Ambulance Services	$75 per trip

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
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	$20 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	$40 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed $150) for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
Base DME items as described in the *EOC*	20% Coinsurance

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Durable Medical Equipment (DME)	You Pay
Supplemental DME items up to a $2,000 benefit limit per Accumulation Period as described in the *EOC*	20% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$250 per admission
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$250 per admission
Individual outpatient substance use disorder evaluation and treatment	$15 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
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Hearing aids every 36 months	Amount in excess of $3,500 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
Fertility Services (such as outpatient procedures or laboratory tests) as described in the *EOC* (oocyte retrievals limited to three per lifetime)	The Cost Share you would pay if the Services were to treat any other condition

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).