

Disclosure Form Part One

225935 ENSIGN UNITED STATES DRILLING
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 (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	\$3,000	\$3,000	\$6,000
Plan Deductible	\$1,500	\$1,500	\$3,000
Drug Deductible	None	None	None

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

\$20 per visit after Plan Deductible

\$20 per visit after Plan Deductible

No charge (Plan Deductible doesn't apply)

No charge (Plan Deductible doesn't apply)

No charge (Plan Deductible doesn't apply)

\$20 per visit after Plan Deductible

\$20 per visit 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 (Plan Deductible doesn't apply)

No charge (Plan Deductible doesn't apply)

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

MRI, most CT, and PET scans.....

You Pay

20% Coinsurance after Plan Deductible

No charge (Plan Deductible doesn't apply)

\$10 per encounter after Plan Deductible

No charge (Plan Deductible doesn't apply)

20% Coinsurance up to a maximum of \$150 per procedure after Plan Deductible

Hospital Inpatient Services

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

You Pay

20% Coinsurance after Plan Deductible

Emergency Services

Emergency department visits

You Pay

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.....

You Pay

\$150 per trip after Plan Deductible

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 (Plan Deductible doesn't apply)

Most generic (Tier 1) refills through our mail-order service..... \$20 for up to a 100-day supply (Plan Deductible doesn't apply)

Most brand-name items (Tier 2) at a Plan Pharmacy..... \$30 for up to a 30-day supply (Plan Deductible doesn't apply)

(continues)

Disclosure Form Part One*(continued)***Prescription Drug Coverage****You Pay**

Most brand-name (Tier 2) refills through our mail-order service	\$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed \$250) for up to a 30-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment (DME)**You Pay**

DME items as described in the <i>EOC</i>	20% Coinsurance (Plan Deductible doesn't apply)
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Mental Health Services**You Pay**

Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	\$20 per visit after Plan Deductible
Group outpatient mental health treatment	\$10 per visit after Plan Deductible

Substance Use Disorder Treatment**You Pay**

Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	\$20 per visit after Plan Deductible
Group outpatient substance use disorder treatment	\$5 per visit after Plan Deductible

Home Health Services**You Pay**

Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
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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 <i>EOC</i>	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 <i>EOC</i>	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 or call Member Services at 1-800-464-4000 (TTY users call 711).