Disclosure Form Part One

21821 TRAVIS UNIFIED SCHOOLS
Home Region: Northern California
1/1/26 through 12/31/26

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	$6,000	$6,000	$12,000
Plan Deductible	$4,500	$4,500	$9,000
Drug Deductible	$250	$250	Not applicable

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$50 per visit after Plan Deductible
Most Physician Specialist Visits	$50 per visit after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$50 per visit after Plan Deductible
Most physical, occupational, and speech therapy	$50 per visit after Plan Deductible

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	40% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	40% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	40% Coinsurance up to a maximum of $150 per procedure after Plan Deductible

Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	40% Coinsurance after Plan Deductible

Emergency Services and Care	**You Pay**
Emergency department visits	$250 per visit 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	**You Pay**
Ambulance Services	40% Coinsurance after Plan Deductible

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$15 for up to a 30-day supply (Drug Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service	$30 for up to a 100-day supply (Drug Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy	$35 for up to a 30-day supply after Drug Deductible

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Prescription Drug Coverage	You Pay
Most brand-name (Tier 2) refills through our mail-order service	$70 for up to a 100-day supply after Drug Deductible
Most specialty items (Tier 4) at a Plan Pharmacy	30% Coinsurance (not to exceed $150) for up to a 30-day supply after Drug Deductible
Durable Medical Equipment (DME)	**You Pay**
Base DME items as described in the *EOC* (supplemental DME items are not covered)	40% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	40% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$50 per visit after Plan Deductible
Group outpatient mental health treatment	$25 per visit after Plan Deductible
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	40% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$50 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)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	40% Coinsurance after Plan Deductible
Base prosthetic and orthotic devices as described in the *EOC* (supplemental prosthetic and orthotic devices are not covered)	No charge (Plan Deductible doesn't apply)
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).