## **Disclosure Form Part One**

603059 NATIONAL SEATING & MOBILITY - NORTH

Home Region: Northern California

1/1/22 through 12/31/22

## Principal benefits for Kaiser Permanente Deductible HMO Plan

**Self-Only Coverage** 

(a Family of one Member)

## **Accumulation Period**

The Accumulation Period for this plan is January 1 through December 31.

## **Out-of-Pocket Maximums and Deductibles**

**Amounts Per Accumulation Period** 

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.

Family Coverage

Each Member in a Family of

two or more Members

**Family Coverage** 

Entire Family of two or more

Members

Plan Deductible   \$1,500   \$1,500   \$3,000   Drug Deductible   None   None   None   Professional Services (Plan Provider office visits)  Wost Primary Care Visits and most Non-Physician Specialist Visits   \$40 per visit (Plan Deductible doesn't apply)   Most Physician Specialist Visits   \$40 per visit (Plan Deductible doesn't apply)   Routine physical maintenance exams, including well-woman exams   No charge (Plan Deductible doesn't apply)   Routine physical maintenance exams including well-woman exams   No charge (Plan Deductible doesn't apply)   Family planning counseling and consultations   No charge (Plan Deductible doesn't apply)   Family planning counseling and consultations   No charge (Plan Deductible doesn't apply)   Routine eye exams with a Plan Optometrist   No charge (Plan Deductible doesn't apply)   Routine eye exams with a Plan Optometrist   No charge (Plan Deductible doesn't apply)   Routine eye exams with a Plan Optometrist   No charge (Plan Deductible doesn't apply)   Routine eye exams with a Plan Optometrist   No charge (Plan Deductible doesn't apply)   Routine services   You Pay    Outpatient Surgery and certain other outpatient procedures   30% Coinsurance after Plan Deductible   Allergy antigens (including administration)   No charge effer Plan Deductible   Most Immunizations (including the vaccine)   No charge effer Plan Deductible doesn't apply)   Most X-rays and laboratory tests as described in the EOC   No charge (Plan Deductible doesn't apply)   Preventive X-rays, screenings, and laboratory tests as described in the EOC   No charge (Plan Deductible doesn't apply)   Proventive X-rays, screenings, and laboratory tests, and drugs   30% Coinsurance after Plan Deductible   Preventive X-rays, screenings, and laboratory tests, and drugs   30% Coinsurance after Plan Deductible   Preventive X-rays, screenings, and laboratory tests, and drugs   30% Coinsurance after Plan Deductible   Preventive X-rays, screenings, and laboratory tests, and drugs   30% Coinsurance after Plan Deductible   Preventiv	Plan Out-of-Pocket Maximum	\$4,000	\$4,000	\$8,000	
Professional Services (Plan Provider office visits)  Most Physician Specialist Visits and most Non-Physician Specialist Visits  \$40 per visit (Plan Deductible doesn't apply)  Routine physical maintenance exams, including well-woman exams  No charge (Plan Deductible doesn't apply)  Routine physical maintenance exams, including well-woman exams  No charge (Plan Deductible doesn't apply)  Family planning counseling and consultations  No charge (Plan Deductible doesn't apply)  Family planning counseling and consultations  No charge (Plan Deductible doesn't apply)  Routine eye exams with a Plan Optometrist  No charge (Plan Deductible doesn't apply)  Routine eye exams with a Plan Optometrist  No charge (Plan Deductible doesn't apply)  Routine eye exams with a Plan Optometrist  No charge (Plan Deductible doesn't apply)  Routine eye exams with a Plan Optometrist  No charge (Plan Deductible doesn't apply)  Routine eye exams with a Plan Optometrist  No charge (Plan Deductible doesn't apply)  Routine eye exams with a Plan Optometrist  No charge (Plan Deductible doesn't apply)  Routine acre consultations, evaluations, and treatment.  \$40 per visit (Plan Deductible doesn't apply)  Brown and part and certain other outpatient procedures  **Outpatient Services**  **Outpatient Services**  **Outpatient Surgery and certain other outpatient procedures  **Outpatient Surgery and certain other outpatient procedures  **State Plan Deductible Apply  Most X-rays and laboratory tests  **State Plan Deductible Apply  **No charge (Plan Deductible doesn't apply)  Most Deriver and Early Plan Deductible for apply)  **Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  **Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  **Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  **Solonium and the Plan Deductible Apply  **Pou Pay**  **Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  **Solonium and the Plan Deductible Apply  **Solonium and the Plan Deductib	=	\$1,500	\$1,500		
Most Primary Care Visits and most Non-Physician Specialist Visits   \$40 per visit (Plan Deductible doesn't apply)	Drug Deductible	None	None	None	
Most Physician Specialist Visits	Professional Services (Plan Provider of	You Pay	You Pay		
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)  Scheduled prenatial care exams  No charge (Plan Deductible doesn't apply)  Scheduled prenatial care exams  No charge (Plan Deductible doesn't apply)  No charge (Plan Deductible doesn't apply)  No charge (Plan Deductible doesn't apply)  Worden exams with a Plan Optometrist.  No charge (Plan Deductible doesn't apply)  Urgent care consultations, evaluations, and treatment.  \$40 per visit (Plan Deductible doesn't apply)  Wost physical, occupational, and speech therapy  \$40 per visit (Plan Deductible doesn't apply)  Wost physical, occupational, and speech therapy  Wost physical maintenance after Plan Deductible  Outpatient Services  You Pay  Outpatient surgery and certain other outpatient procedures  30% Coinsurance after Plan Deductible  No charge (Plan Deductible doesn't apply)  Most X-rays and laboratory tests.  \$15 per encounter after Plan Deductible  No charge (Plan Deductible doesn't apply)  Most X-rays, screenings, and laboratory tests as described in the EOC  No charge (Plan Deductible doesn't apply)  MRI, most CT, and PET scans  30% 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  30% Coinsurance up to a maximum of \$150 per procedure after Plan Deductible  Prescripton Services  You Pay  Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.  30% Coinsurance after Plan Deductible  Prescripton Drug Coverage  You Pay  Ambulance Services  You Pay  Ambulance Services  You Pay  Most generic items (Tier 1) at a Plan Pharmacy.  \$150 per trip after Plan Deductible doesn't apply)  Most prand-name items (Tier 2) at a Plan Pharmacy.  \$20 for up to a 30-day supply (Plan Deductible doesn't apply)  Most brand-name (Tier 2) refills through our mail-order service  \$20 for					
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Most brand-name (Tier 2) refills through our mail-order service	Room and board, surgery, anesthesia, X-ra  Emergency Health Coverage  Emergency Department visits  Note: If you are admitted directly to the hos the Emergency Department Cost Share (s  Ambulance Services  Ambulance Services  Prescription Drug Coverage  Covered outpatient items in accord with out Most generic items (Tier 1) at a Plan Pha	pital as an inpatient for covered ee "Hospitalization Services" for the services of the services of the services of the service of the servic	30% Coinsurance aft You Pay 30% Coinsurance aft Services, you will pay the inpat r inpatient Cost Share) You Pay \$150 per trip after Pla You Pay \$10 for up to a 30-da doesn't apply) \$20 for up to a 100-d doesn't apply)	er Plan Deductible tient Cost Share instead of an Deductible y supply (Plan Deductible ay supply (Plan Deductible	
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Most specialty items (Tier 4) at a Plan Pharmacy	Room and board, surgery, anesthesia, X-ra  Emergency Health Coverage  Emergency Department visits  Note: If you are admitted directly to the hos the Emergency Department Cost Share (s  Ambulance Services  Ambulance Services  Prescription Drug Coverage  Covered outpatient items in accord with our Most generic items (Tier 1) at a Plan Pha  Most generic (Tier 1) refills through our most brand-name items (Tier 2) at a Plan	pital as an inpatient for covered ee "Hospitalization Services" for the services of the services of the services of the service of the servic	30% Coinsurance aft You Pay 30% Coinsurance aft Services, you will pay the inpat r inpatient Cost Share) You Pay \$150 per trip after Pla You Pay \$10 for up to a 30-da doesn't apply) \$20 for up to a 100-d doesn't apply) \$30 for up to a 30-da doesn't apply) \$30 for up to a 30-da doesn't apply)	er Plan Deductible tient Cost Share instead of an Deductible y supply (Plan Deductible ay supply (Plan Deductible y supply (Plan Deductible	
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Durable Medical Equipment (DME) You Pay	Room and board, surgery, anesthesia, X-ra  Emergency Health Coverage  Emergency Department visits  Note: If you are admitted directly to the hos the Emergency Department Cost Share (s  Ambulance Services  Ambulance Services  Ambulance Services  Covered outpatient items in accord with our Most generic items (Tier 1) at a Plan Pha  Most generic (Tier 1) refills through our most brand-name items (Tier 2) at a Plan  Most brand-name (Tier 2) refills through	pital as an inpatient for covered ee "Hospitalization Services" for drug formulary guidelines: armacy	30% Coinsurance aft You Pay 30% Coinsurance aft Services, you will pay the inpat r inpatient Cost Share) You Pay \$150 per trip after Pla You Pay \$10 for up to a 30-da doesn't apply) \$20 for up to a 100-d doesn't apply) \$30 for up to a 30-da doesn't apply) \$60 for up to a 100-d doesn't apply)	er Plan Deductible cient Cost Share instead of an Deductible  y supply (Plan Deductible ay supply (Plan Deductible y supply (Plan Deductible ay supply (Plan Deductible ay supply (Plan Deductible ay supply (Plan Deductible at to exceed \$250) for up to a	
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DME items as described in the EOC	Room and board, surgery, anesthesia, X-ra  Emergency Health Coverage  Emergency Department visits  Note: If you are admitted directly to the hos the Emergency Department Cost Share (sometime in the Emergency Department Cost Sha	pital as an inpatient for covered ee "Hospitalization Services" for drug formulary guidelines: armacy	30% Coinsurance aft You Pay 30% Coinsurance aft Services, you will pay the inpat r inpatient Cost Share) You Pay \$150 per trip after Pla You Pay \$10 for up to a 30-da doesn't apply) \$20 for up to a 100-d doesn't apply) \$30 for up to a 30-da doesn't apply) \$60 for up to a 100-d doesn't apply) \$60 for up to a 100-d doesn't apply) \$60 for up to a 100-d doesn't apply) \$00 Coinsurance (no 30-day supply (Plan You Pay	er Plan Deductible cient Cost Share instead of an Deductible  y supply (Plan Deductible ay supply (Plan Deductible y supply (Plan Deductible ay supply (Plan Deductible ay supply (Plan Deductible ay supply (Plan Deductible but to exceed \$250) for up to a Deductible doesn't apply)	

Disclosure Form Part One	(continued)
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	\$40 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	
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)  Prosthetic and orthotic devices as described in the <i>EOC</i> Diagnosis and treatment of infertility and artificial insemination (such as outpatient	30% Coinsurance after Plan Deductible No charge (Plan Deductible doesn't apply)
procedures or laboratory tests) as described in the EOC	
Assisted reproductive technology ("ART") Services	
Hospice care	No charge (Plan Deductible doesn't apply)

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*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).