Disclosure Form Part One

30018 PRISM - CITY OF CLOVIS
Home Region: Northern California
1/1/23 through 12/31/23

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	40% Coinsurance after Plan Deductible
Most Physician Specialist Visits	40% Coinsurance 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)
Scheduled prenatal care exams	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	40% Coinsurance after Plan Deductible
Most physical, occupational, and speech therapy	40% Coinsurance after Plan Deductible

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

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

Emergency Health Coverage	**You Pay**
Emergency Department visits	40% 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 "Hospitalization 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 or through our mail-order service	30% Coinsurance (not to exceed $50) for up to a 100-day supply (Drug Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	40% Coinsurance (not to exceed $100) for up to a 100-day supply after Drug Deductible
Most specialty items (Tier 4) at a Plan Pharmacy	40% Coinsurance (not to exceed $100) for up to a 30-day supply after Drug Deductible

(continues)

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	40% Coinsurance after Plan Deductible
Group outpatient mental health treatment	40% Coinsurance after Plan Deductible
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	40% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	40% Coinsurance after Plan Deductible
Group outpatient substance use disorder treatment	40% Coinsurance 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)
Diagnosis and treatment of infertility and artificial insemination	Not covered
Assisted reproductive technology ("ART") Services	Not covered
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).