## **Disclosure Form Part One**

35962 PATHWAYS HOME HEALTH AND HOSPICE Home Region: Northern California 7/1/24 through 6/30/25

## 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.

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 Physician Specialist Visits \$15 per visit   Most Physician Specialist Visits \$15 per visit   Routine physical maintenance exams, including well-woman exams. No charge   Scheduled prenatal care exams. No charge   Scheduled prenatal care exams, including well-woman exams. No charge   Vell-child preventive exams with Palo Optometrist. No charge   Most physical, occupational, and speech therapy. \$15 per visit   Telehealth Visits You Pay   Primary Care Visits and Non-Physician Specialist Visits by interactive No charge   Physician Specialist Visits by interactive video No charge   Physician Specialist Visits by interactive video No charge   Outpatient Services You Pay   Outpatient Services You Pay   Outpatient Services You Pay   Room and board, surgery, anesthesia, X-rays, laboratory tests, and Arge exited 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 instead of the emergency department Cost Share (see "Hospital Inpatie	Amounts Per Accumulation Period	<b>Self-Only Coverage</b> (a Family of one Member)	Family Coverage Each Member in a Family	Family Coverage Entire Family of two or	
Plan Deductible     None     None     None       Drug Deductible     None     None     None     None       Most Privation Specialist Visits     \$15 per visit     \$15 per visit     None     None       Most Prysician Specialist Visits     \$15 per visit     \$15 per visit     No charge       Well-child preventive exams (through age 23 months)     No charge     No charge       Scheduled prenatal care exams     No charge     No charge       Well-child preventive exams (through age 23 months)     No charge     No charge       Scheduled prenatal care exams     No charge     No charge       Word Physical occupational, and speech therapy     \$15 per visit     Telehealth Visits       Telehealth Visits     You Pay     You Pay       Primary Care Visits and Non-Physician Specialist Visits by interactive video     No charge     No charge       Physician Specialist Visits by telephone     No charge     No charge       Outpatient Services     You Pay     You Pay       Coutpatient Services     You Pay     No charge       Most Targery and certain other outpatient procedures     \$15 per procedure     No charge	Plan Out of Pookat Maximum	, ,	of two or more Members	more Members	
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Most brand-name items (Tier 2) at a Plan Pharmacy\$20 for up to a 30-day supplyMost brand-name (Tier 2) refills through our mail-order service\$40 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$20% Coinsurance (not to exceed \$250) for up to a 30-day supplyDurable Medical Equipment (DME)You PayDME items as described in the EOC20% CoinsuranceMental Health ServicesYou Pay					
Most brand-name (Tier 2) refills through our mail-order service\$40 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy20% Coinsurance (not to exceed \$250) for up to a 30-day supplyDurable Medical Equipment (DME)You PayDME items as described in the EOC20% CoinsuranceMental Health ServicesYou Pay					
Most specialty items (Tier 4) at a Plan Pharmacy   20% Coinsurance (not to exceed \$250) for up to a 30-day supply     Durable Medical Equipment (DME)   You Pay     DME items as described in the EOC   20% Coinsurance     Mental Health Services   You Pay					
Durable Medical Equipment (DME) You Pay   DME items as described in the EOC 20% Coinsurance   Mental Health Services You Pay					
Mental Health Services You Pay				30-day supply	
Mental Health Services You Pay	Durable Medical Equipment (DME)		You Pay		
	DME items as described in the EOC		20% Coinsurance	20% Coinsurance	
Inpatient psychiatric hospitalization					
	Inpatient psychiatric hospitalization		No charge		

Disclosure Form Part One	(continued)
Mental Health Services	You Pay
Individual outpatient mental health evaluation and treatment	
Group outpatient mental health treatment	\$7 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
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
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the EOC	No charge
Services to diagnose or treat infertility and artificial insemination (such	
as outpatient procedures or laboratory tests) as described in the	the Cost Share you would pay if the Services were
EOC	to treat any other condition
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-ofpocket 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).