## **Disclosure Form Part One**

229297 PRISM - COUNTY OF SANTA BARBARA Home Region: Southern California 1/1/24 through 12/31/24

## Principal benefits for Kaiser Permanente Traditional HMO Plan

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call Member Services.

## 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.

Primary Care Visits and Non-Physician Specialist Visits by interactive       No charge         Physician Specialist Visits by interactive video       No charge         Primary Care Visits and Non-Physician Specialist Visits by telephone       No charge         Physician Specialist Visits by telephone       No charge         Physician Specialist Visits by telephone       No charge         Outpatient Services       You Pay         Most immunizations (including the vaccine)       No charge         Most X-rays and laboratory tests       No charge         Hospital Inpatient Services       No charge         Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs       \$100 per admission         Emergency Services       You Pay         Emergency department visits       \$100 per visit         Note arge       \$100 per visit         Prescription Drug Coverage       \$10 per visit         Most generic (Tier 1) refills through our mail-order service       \$10 for up to a 30-d	Accultulation Fellou once you have re				
Amounts Per Accumulation Period Plan Out-of-Pocket Maximum       (a Family of wood members) of twood more Members       Endo Members       more Members       more Members       more Members         Plan Deductible       None       None       None       None         Drug Deductible       None       None       None       None         Most Primary Care Visits and most Non-Physician Specialist Visits.       \$15 per visit       S15 per visit         Most Primary Care Visits and most Non-Physician Specialist Visits.       \$15 per visit       No charge         Well-child preventive exams (through age 23 months)       No charge       No charge         Routine eye exams with a Plan Optometrist       No charge       No charge         Urgent care consultations, evaluations, and treatment       \$15 per visit       You Pay         Primary Care Visits and Non-Physician Specialist Visits by interactive video       No charge       No charge         Physician Specialist Visits by interactive video       No charge       No charge         Outpatient Services       You Pay       No charge         Outpatient Services       You Pay       No charge         Nos charge       No charge       No charge         Most Primary Care Visits and Non-Physician Specialist Visits by telephone       No charge         Outpatient Services       \$15 per p		Self-Only Coverage			
Plan Out-of-Pocket Maximum       \$1,500       \$1,500       \$1,500         Plan Deductible       None       None       None         Drug Deductible       None       None       None         Plan Provider Office Visits       None       None       None         Most Primary Care Visits and most Non-Physician Specialist Visits.       \$15 per visit         Routine physical maintenance exams, including well-woman exams.       No charge         Scheduled preventive exams (through age 23 months)       No charge         Scheduled preventive exams (through age 23 months).       No charge         Scheduled preventive exams (through age 23 months).       No charge         Well-child preventive exams (through age 23 months).       No charge         Routine eye exams with a Plan Optometrist       No charge         Urgent care consultations, evaluations, and treatment       \$15 per visit         Most physical, occupational, and speech therapy.       \$15 per visit         Telehealth Visits       You Pay         Primary Care Visits and Non-Physician Specialist Visits by interactive video       No charge         Physician Specialist Visits by interactive video       No charge         Voutpatient Services       You Pay         Room and board, surgery, anesthesia, X-rays, laboratory tests, and       \$10 per visit	Amounts Per Accumulation Period				
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Most Primary Care Visits and most Non-Physician Specialist Visits	Drug Deductible	None	None	None	
Most Primary Care Visits and most Non-Physician Specialist Visits	Plan Provider Office Visits		You Pay		
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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 ServicesYou PayAmbulance Services.\$50 per tripPrescription Drug CoverageYou PayCovered outpatient items in accord with our drug formulary guidelines: Most generic (Tier 1) at a Plan Pharmacy\$10 for up to a 30-day supplyMost brand-name items (Tier 2) at a Plan Pharmacy.\$30 for up to a 100-day supplyMost brand-name (Tier 2) refills through our mail-order service\$60 for up to a 100-day supplyMost brand-name (Tier 2) refills through our mail-order service\$60 for up to a 100-day supplyMost brand-name (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan Pharmacy\$60 for up to a 100-day supplyMost specialty items (Tier 4) at a Plan P	Emergency Services		You Pay	You Pay	
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Durable Medical Equipment (DME)       You Pay         DME items as described in the EOC       No charge	Most specialty items (Tier 4) at a Plai	n Pharmacy		o exceed \$150) for up to a	
DME items as described in the EOC No charge	Durable Medical Equipment (DME)		You Pay		
	DME items as described in the EOC		No charge		

Disclosure Form Part One	(continued)
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	\$100 per admission
Individual outpatient mental health evaluation and treatment	
Group outpatient mental health treatment	\$7 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$100 per admission
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
Diagnosis and treatment of infertility and artificial insemination (such	
as outpatient procedures or laboratory tests) as described in the	
EOC	
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge
This is a summary of the most frequently asked-about benefits. This ch	art does not explain benefits. Cost Share, out-of-

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).