
Disclosure Form Part One

607376 Wedgewood Village Pharmacy, LLC
Home Region: Northern California
4/1/23 through 3/31/24

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	\$3,000	\$3,000	\$6,000
Plan Deductible	\$750	\$750	\$1,500
Drug Deductible	None	None	None

Plan Provider Office Visits

	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits.....	\$25 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	\$25 per visit (Plan Deductible doesn't apply)
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	\$25 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	\$25 per visit 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	20% Coinsurance after Plan Deductible
Most immunizations (including the vaccine).....	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests.....	\$10 per encounter 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.....	20% Coinsurance up to a maximum of \$150 per procedure after Plan Deductible

Hospitalization Services

	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible

Emergency Health Coverage

	You Pay
Emergency Department visits	20% 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.....	\$150 per trip 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	\$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service	\$20 for up to a 100-day supply (Plan Deductible doesn't apply)

(continues)

Disclosure Form Part One*(continued)***Prescription Drug Coverage**

	You Pay
Most brand-name items (Tier 2) at a Plan Pharmacy.....	\$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name (Tier 2) refills through our mail-order service	\$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed \$250) for up to a 30-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment (DME)

DME items as described in the <i>EOC</i>	20% Coinsurance (Plan Deductible doesn't apply)
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Mental Health Services

Inpatient psychiatric hospitalization.....	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	\$25 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment.....	\$12 per visit (Plan Deductible doesn't apply)

Substance Use Disorder Treatment

Inpatient detoxification.....	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	\$25 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	\$5 per visit (Plan Deductible doesn't apply)

Home Health Services

Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
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Other

Eyeglasses or contact lenses:	
Eyeglass frame every 24 months	Amount in excess of \$130 Allowance (Allowance not subject to Plan Deductible)
Regular eyeglass lenses every 12 months.....	No charge (Plan Deductible doesn't apply)
Contact lenses every 12 months	Amount in excess of \$130 Allowance (Allowance not subject to Plan Deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i>	50% Coinsurance (Plan Deductible doesn't apply)
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).