## **Disclosure Form Part One**

101829 CALIFORNIA INSTITUTE OF TECHNOLOGY Home Region: Southern California 1/1/24 through 12/31/24

## 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.

Image: Instrument of the second state of two or more Members     more Members       Plan Out-of-Pocket Maximum     \$1,500     \$1,500     \$3,000       Plan Deductible     None     None     None     None       Drug Deductible     None     None     None     None       Most Privationa Specialist Visits     \$25 per visit     \$35 per visit     \$35 per visit       Routine physical maintenance exams, including well-woman exams.     No charge     No charge       Routine physical maintenance exams.     No charge     No charge       Routine eye exams with a Plan Optometrist     No charge     No charge       Primary Care Visits and Non-Physician Specialist Visits by interactive     You Pay       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       Most Physician Specialist Visits by telephone.     No charge       Most Arays and laboratory tests.     No charge       Most Arays and laboratory tests.     No charge       Most Arays and laboratory tests.     No charge       Most I poly are admitted directly	Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	<b>Family Coverage</b> Each Member in a Family	Family Coverage Entire Family of two or	
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Drug Deductible     None     None     None       Plan Provider Office Visits     You Pay       Most Primary Care Visits and most Non-Physician Specialist Visits.     \$35 per visit       Routine physician Specialist Visits     \$35 per visit       Routine physician Specialist Visits     \$35 per visit       Routine eye exams with a Plan Optometrist     No charge       Boutine eye exams with a Plan Optometrist     No charge       Urgent care consultations, evaluations, and treatment     \$25 per visit       Telehealth Visits     No charge       Primary Care Visits and Non-Physician Specialist Visits by interactive video     No charge       Physician Specialist Visits by interactive video     No charge       Physician Specialist Visits by telephone     No charge       Physician Specialist Visits by telephone     No charge       Outpatient Services     You Pay       Outpatient Services     You Pay       Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.     \$250 per visit       Emergency department visits.     \$250 per visit       Ambulance Services     You Pay       Covered outpatient items in accord with our drug formulary guidelines: instead of the emergency department Cost Share (see			. ,	. ,	
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Mental Health Services   You Pay     Inpatient psychiatric hospitalization   \$250 per admission	Durable Medical Equipment (DME)		You Pay		
Inpatient psychiatric hospitalization \$250 per admission			-	-	
	Mental Health Services		You Pay	You Pay	
Individual outpatient mental health evaluation and treatment \$25 per visit					

Disclosure Form Part One	(continued)
Mental Health Services	You Pay
Group outpatient mental health treatment	\$12 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$250 per admission
Individual outpatient substance use disorder evaluation and treatment	
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	see EOC for Cost Share
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).