Disclosure Form Part One

107713 DOWNEY UNIFIED SCHOOL DISTRICT Home Region: Southern California 10/1/23 through 9/30/24

Principal benefits for Kaiser Permanente Deductible HMO Plan with HRA

Accumulation Period

The Accumulation Period for this plan is 10/1/23 through 9/30/24 (contract year).

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.

Primary Care Visits and Non-Physician Specialist Visits by interactive 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) 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. Preventive X-rays, screenings, and laboratory tests as described in the EOC MRI, most CT, and PET scans No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans. You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs 20% Coinsurance after Plan Deductible Mergency Health Coverage You Pay Emergency Department visits 20% Coinsurance after Plan Deductible Vote: 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					
(at Pathing of other Member) of two or more Members more Members Plan Out-of-Pocket Maximum \$2.000 \$4.000 Plan Deductible \$1,000 \$1,000 \$2,000 Program \$1,000 \$1,000 \$2,000 Program None None None Plan Provider Office Visits You Pay \$20 per visit after Plan Deductible Most Primary Care Visits and most Non-Physician Specialist Visits \$20 per visit after Plan Deductible desn't apply) Well-child preventive exams (through age 23 months) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Scheduled preventive exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy	Amounto Day Accumulation Davied	Self-Only Coverage			
Pian Deductible \$2,000 \$4,000 Plan Deductible \$1,000 \$1,000 \$2,000 Drug Deductible None None None None Plan Provider Office Visits You Pay \$20 per visit after Plan Deductible \$20 per visit after Plan Deductible Most Physician Specialist Visits \$20 per visit after Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams. including well-woman exams. No charge (Plan Deductible doesn't apply) Most Physical maintenance exams. including well-woman exams. No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams. with a Plan Optometrist. No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$20 per visit after Plan Deductible Teleheath Visits You Pay Primary Care Visits and Non-Physician Specialist Visits by interactive No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Outpatient Services You Pay 20% Coinsurance	Amounts Per Accumulation Period	(a Family of one Member)			
Plan Deductible \$1,000 \$1,000 \$2,000 Drug Deductible None None None None Plan Provider Office Visits You Pay Most 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) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Kost physical maintenance exams, and treatment. S20 per visit after Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. S20 per visit after Plan Deductible 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) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient Services You Pay Outpatient Services No charge (Plan Deductible doesn't apply) No	Plan Out-of-Pocket Maximum	\$2,000			
Drug Deductible None None None Plan Provider Office Visits You Pay You Pay Most Primary Care Visits and most Non-Physician Specialist Visits. \$20 per visit after Plan Deductible \$20 per visit after Plan Deductible Routine physical maintenance exams, including well-woman exams. No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams, evaluations, and treatment. \$20 per visit after Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$20 per visit after Plan Deductible doesn't apply) Most physical Specialist Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) 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 Services You Pay Not charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Most immunizations (including the vaccine). No charge (Plan Deductible doesn't apply) <tr< td=""><td></td><td></td><td>· ,</td><td></td></tr<>			· ,		
Plan Provider Office Visits You Pay Wost Prysician Specialist Visits \$20 per visit after Plan Deductible Most Physical Specialist Visits \$20 per visit after Plan Deductible Routine physical maintenance exams, including well-woman exams No charge (Plan Deductible doesn't apply) Not harge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy \$20 per visit after Plan Deductible Most physical, occupational, and speech therapy \$20 per visit after Plan Deductible Primary Care Visits and Non-Physician Specialist Visits by interactive video You Pay No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Nothares (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Outpatient surgery and certain other outpatient procedures 20% Coinsurance after Plan Deductible Most T-rays, screenings, and laboratory tests as described in the ECC No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans 20% Coinsurance after Plan Deductible				. ,	
Most Primary Care Visits and most Non-Physician Specialist Visits. \$20 per visit after Plan Deductible Most Physician Specialist Visits \$20 per visit after Plan Deductible Most Physician 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 prevative exams (through age 23 months). No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$20 per visit after Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$20 per visit after Plan Deductible doesn't apply) 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) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient Services You Pay Most immunizations (including the vaccine). No charge (Plan Deductible doesn't apply) Most and aboratory tests. Anal laboratory tests as described in the ECC . Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. You Pay Noc Cansurance after P		None		None	
Most Physician Specialist Visits \$20 per visit after Plan Deductible Routine physical maintenance exams, including well-woman exams. No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams. No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams. No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams. No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams. No charge (Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$20 per visit after Plan Deductible doesn't apply) Most physical, occupational, and speech therapy. \$20 per visit after Plan Deductible doesn't apply) Primary Care Visits and Non-Physician Specialist Visits by interactive video. No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone. No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Outpatient Services You Pay Outpatient Services You Pay Nost X-rays, and laboratory tests. \$10 per encounter after Plan Deductible Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs. 20% Coinsurance after Plan Deductible Note: You Pay Corresol Upeartment vists. 20% Coinsurance after Plan Deduct					
Routine physical maintenance exams, including well-woman exams					
Well-ohid preventive exams (through age 23 months) No charge (Plan Deductible doesn't apply) Scheduled prenatal care exams No charge (Plan Deductible doesn't apply) Scheduled reveatas with a Plan Optometrist No charge (Plan Deductible doesn't apply) Woot hysical, occupational, and speech therapy \$20 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) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply) No trays and laboratory tests No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests So forisurance after Plan Deductible Most X-rays and laboratory tests No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests No charge (Plan Deductible do					
Scheduled prenatal care exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) Routine eye exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) Wost physical, occupational, and speech therapy. \$20 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) 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) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Outpatient Services You Pay Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most immunization Services 20% Coinsurance after Plan Deductible Preventive X-rays, screenings, and laboratory tests, and drugs No charge (Plan Deductible doesn't apply) Mort preventive X-rays, screenings, and laboratory tests, and drugs You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and dru					
Routine eyé exams with a Plan Optometrist No charge (Plan Deductible doesn't apply) Urgent care consultations, evaluations, and treatment \$20 per visit after Plan Deductible Most physical, occupational, and speech therapy. \$20 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) 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 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 Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs 20% Coinsurance after Plan Deductible Rome and board, surgery, anesthesia, X-rays, laboratory tests, and furger 20% Coinsurance after Plan Deductible You Pay 20% Coinsurance after Plan Deductible Prescript					
Urgent care consultations, evaluations, and treatment \$20 per visit after Plan Deductible Most physical, occupational, and speech therapy \$20 per visit after Plan Deductible Most physical, occupational, and speech therapy \$20 per visit after Plan Deductible Primary Care Visits and Non-Physician Specialist Visits by interactive No charge (Plan Deductible doesn't apply) Physician Specialist Visits by interactive video No charge (Plan Deductible doesn't apply) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) Outpatient surgery and certain other outpatient procedures 20% Coinsurance after Plan Deductible Most X-rays, and laboratory tests, and laboratory tests as described in \$10 per encounter after Plan Deductible Preventive X-rays, screenings, and laboratory tests, and aboratory tests, and aboratory tests, and aboratory tests, and per encounter after Plan Deductible No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans \$10 per encounter after Plan Deductible You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and rugs. 20% Coinsurance after Plan Deductible You Pay Remegnecy Department visits 20% Coinsurance after Plan Deductible You Pay Room and board, surgery, anesthesia, X-rays, laboratory tests, and rugs. 20% Coinsurance after Plan Deductible Y					
Most physical, occupational, and speech therapy					
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) 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 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 <i>EOC</i> 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 Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs 20% Coinsurance after Plan Deductible You Pay 20% Coinsurance after Plan Deductible Prescription Drug Coverage You Pay Covered outpatient items in accord with our drug formulary guidelines: Most generic (Tier 1) refills through our mail-order service \$10 per tip after Plan Deductible Most generic (Tier 1) refills through our mail-order service \$10 put to a					
Primary Care Visits and Non-Physician Specialist Visits by interactive 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 20% Coinsurance after Plan Deductible Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most and laboratory tests \$10 per encounter after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans \$10 per encounter after Plan Deductible Most generic Yeath Visits X-rays, laboratory tests, and drugs 20% Coinsurance up to a maximum of \$150 per procedure after Plan Deductible Most generic tiems (maximum visits X-rays, laboratory tests, and drugs 20% Coinsurance after Plan Deductible You Pay 20% Coinsurance after Plan Deductible<	Most physical, occupational, and speech therapy		\$20 per visit after Plan	•	
videoNo charge (Plan Deductible doesn't apply)Physician Specialist Visits by interactive videoNo charge (Plan Deductible doesn't apply)Physician Specialist Visits by telephoneNo charge (Plan Deductible doesn't apply)Physician Specialist Visits by telephoneNo charge (Plan Deductible doesn't apply)Physician Specialist Visits by telephoneNo charge (Plan Deductible doesn't apply)Outpatient ServicesYou PayOutpatient surgery and certain other outpatient procedures20% Coinsurance after Plan DeductibleMost X-rays and laboratory tests\$10 per encounter after Plan DeductiblePreventive X-rays, screenings, and laboratory tests as described in the EOCNo charge (Plan Deductible doesn't apply)MRI, most CT, and PET scansNo charge (Plan Deductible doesn't apply)MRI, most CT, and PET scansYou PayRoom and board, surgery, anesthesia, X-rays, laboratory tests, and drugsYou PayEmergency Health CoverageYou PayEmergency Department visits20% Coinsurance after Plan DeductibleNote: 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 ServicesYou PayCovered outpatient items in accord with our drug formulary guidelines: Most generic (Tier 1) refills through our mail-order serviceYou PayMost generic (Tier 1) refills through our mail-order service\$10 for up to a 30-day supply (Plan Deductible doesn't apply)You pay\$20 for up to a 100-day supply (Plan De	Telehealth Visits				
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) Physician Specialist Visits by telephone No charge (Plan Deductible doesn't apply) 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 20% Coinsurance 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 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 Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs 20% Coinsurance after Plan Deductible Emergency Department visits 20% Coinsurance after Plan Deductible You Pay 20% Coinsurance after Plan De					
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 Services 20% Coinsurance after Plan Deductible doesn't apply) Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests 20% Coinsurance 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 No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans No charge (Plan Deductible doesn't apply) Moor and board, surgery, anesthesia, X-rays, laboratory tests, and drugs No charge (Plan Deductible doesn't apply) Emergency Health Coverage You Pay Emergency Department visits Proventive X-rays in addited 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 Covered outpatient items in accord with our drug formulary guidelines: %10 for up to a 30-day supply (Plan Deductible doesn't apply) Most generic (Tier 1) refills through our mail-o	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 Services 20% Coinsurance after Plan Deductible doesn't apply) Most immunizations (including the vaccine) No charge (Plan Deductible doesn't apply) Most X-rays and laboratory tests 20% Coinsurance 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 No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans No charge (Plan Deductible doesn't apply) Moor and board, surgery, anesthesia, X-rays, laboratory tests, and drugs No charge (Plan Deductible doesn't apply) Emergency Health Coverage You Pay Emergency Department visits Proventive X-rays in addited 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 Covered outpatient items in accord with our drug formulary guidelines: %10 for up to a 30-day supply (Plan Deductible doesn't apply) Most generic (Tier 1) refills through our mail-o	Physician Specialist Visits by interactive video		. 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) 20% Coinsurance after Plan Deductible Most X-rays and laboratory tests. No charge (Plan Deductible doesn't apply) Preventive X-rays, screenings, and laboratory tests as described in No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans 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 Vote: 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 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-or	Primary Care Visits and Non-Physician Specialist Visits by telephone		ne No charge (Plan Deduc	No charge (Plan Deductible doesn't apply)	
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 No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans 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 You Pay 20% Coinsurance after Plan Deductible Vou Pay 20% Coinsurance after Plan Deductible You Pay 20% Coinsurance after Plan Deductible You Pay 20% Coinsurance after Plan Deductible Vote: 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 Covered outpatient items in accord with our drug formulary guidelines: \$10 for up to a 30-day supply (Plan Deductible doesn't apply) Most generic (Tier 1) refills throug	Physician Specialist Visits by telephone		. No charge (Plan Deductible doesn't apply)		
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 No charge (Plan Deductible doesn't apply) MRI, most CT, and PET scans 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) 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: \$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)	Outpatient Services		You Pay		
Most X-rays and laboratory tests \$10 per encounter after Plan Deductible Preventive X-rays, screenings, and laboratory tests as described in 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 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)					
Preventive X-rays, screenings, and laboratory tests as described in the EOC					
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) You Pay Ambulance Services You Pay Covered outpatient items in accord with our drug formulary guidelines: You Pay Most generic (Tier 1) refills through our mail-order service \$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)	Most X-rays and laboratory tests		\$10 per encounter after Plan Deductible		
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 (see "Hospitalization Services" for inpatient Cost Share) Ambulance Services You Pay Ambulance Services You Pay Covered outpatient items in accord with our drug formulary guidelines: \$150 per trip after Plan Deductible 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)					
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 You Pay Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy You Pay Most generic (Tier 1) refills through our mail-order service \$10 for up to a 30-day supply (Plan Deductible doesn't apply) %20 for up to a 100-day supply (Plan Deductible \$20 for up to a 100-day supply (Plan Deductible	the EOC		No charge (Plan Deduc	No charge (Plan Deductible doesn't apply)	
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) You Pay Ambulance Services You Pay Ambulance Services You Pay Covered outpatient items in accord with our drug formulary guidelines: You Pay 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)	MRI, most CT, and PET scans				
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) 20% Coinsurance after Plan Deductible Ambulance Services You Pay Ambulance Services. You Pay Covered outpatient items in accord with our drug formulary guidelines: You Pay 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	Hospitalization Services		You Pay		
Emergency Health CoverageYou PayEmergency Department visits20% Coinsurance after Plan DeductibleNote: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Shareinstead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share)Ambulance ServicesAmbulance ServicesAmbulance ServicesAmbulance ServicesCovered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan PharmacyMost generic (Tier 1) refills through our mail-order serviceState ServicesState ServicesState Services (Tier 1) refills through our mail-order serviceState ServicesState Service (Tier 1) refills through our mail-order serviceState Service (Tier 1) refills through our mail-or	Room and board, surgery, anesthesia,	X-rays, laboratory tests, and			
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: You Pay 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	drugs		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: You Pay 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	Emergency Health Coverage				
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: You Pay 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					
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: You Pay 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					
Ambulance Services \$150 per trip after Plan Deductible Prescription Drug Coverage You Pay Covered outpatient items in accord with our drug formulary guidelines: \$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)					
Prescription Drug Coverage You Pay Covered outpatient items in accord with our drug formulary guidelines: You Pay 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					
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					
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	Prescription Drug Coverage				
doesn't apply) Most generic (Tier 1) refills through our mail-order service					
Most generic (Tier 1) refills through our mail-order service \$20 for up to a 100-day supply (Plan Deductible	Most generic items (Tier 1) at a Plan Pharmacy				
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)		

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		
Most specialty items (Tier 4) at a Plan Pharmacy		
Durable Medical Equipment (DME)	You Pay	
DME items as described in the EOC	20% Coinsurance (Plan Deductible doesn't apply)	
Mental Health Services	You Pay	
Inpatient psychiatric hospitalization		
Individual outpatient mental health evaluation and treatment		
Group outpatient mental health treatment	\$10 per visit after Plan Deductible	
Substance Use Disorder Treatment	You Pay	
Inpatient detoxification		
Individual outpatient substance use disorder evaluation and treatment		
Group outpatient substance use disorder treatment	\$5 per visit 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)		
Prosthetic and orthotic devices as described in the EOC	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		
Assisted reproductive technology ("ART") Services		
Hospice care	ino charge (Plan Deductible doesn't apply)	
This is a summary of the most frequently asked-about benefits. This ch		

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).