Disclosure Form Part One
38160 SANTA CLARA COUNTY SCHOOLS INSURANCE GROUP
Home Region: Northern California
1/1/23 through 12/31/23

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.

<table>
<thead>
<tr>
<th>Amounts Per Accumulation Period</th>
<th>Self-Only Coverage (a Family of one Member)</th>
<th>Family Coverage Each Member in a Family of two or more Members</th>
<th>Family Coverage Entire Family of two or more Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Out-of-Pocket Maximum</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>$500</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Drug Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Plan Provider Office Visits
Most Primary Care Visits and most Non-Physician Specialist Visits $20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits $20 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 $20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy $20 per visit (Plan Deductible doesn't apply)

Telehealth Visits
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
Outpatient surgery and certain other outpatient procedures 10% 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 (Plan Deductible doesn't apply)
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 10% Coinsurance up to a maximum of $50 per procedure (Plan Deductible doesn't apply)

Hospitalization Services
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs 10% Coinsurance after Plan Deductible

Emergency Health Coverage
Emergency Department visits 10% 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")

Ambulance Services
Ambulance Services $150 per trip (Plan Deductible doesn't apply)

Prescription Drug Coverage
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)

Note: The above is a summary of the principal benefits. For a complete listing of Deductibles, Out-of-Pocket Maximums, and Cost Share amounts, please refer to the full plan document.
Disclosure Form Part One

Prescription Drug Coverage
Most brand-name items (Tier 2) at a Plan Pharmacy ...........................................
Most brand-name (Tier 2) refills through our mail-order service ..............
Most specialty items (Tier 4) at a Plan Pharmacy ..............................................

You Pay
Most brand-name (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 ..............................................
$35 for up to a 30-day supply (Plan Deductible doesn’t apply)

Durable Medical Equipment (DME)
DME items as described in the EOC .............................................................

You Pay
DME items as described in the EOC ..........................................................
20% Coinsurance (Plan Deductible doesn’t apply)

Mental Health Services
Inpatient psychiatric hospitalization ..............................................................

You Pay
Inpatient psychiatric hospitalization ..............................................................
10% Coinsurance after Plan Deductible

Individual outpatient mental health evaluation and treatment ...............

You Pay
Individual outpatient mental health evaluation and treatment ...............
$20 per visit (Plan Deductible doesn’t apply)

Group outpatient mental health treatment ...................................................

You Pay
Group outpatient mental health treatment ...................................................
$10 per visit (Plan Deductible doesn’t apply)

Substance Use Disorder Treatment
Inpatient detoxification ................................................................................

You Pay
Inpatient detoxification ................................................................................
$20 per visit (Plan Deductible doesn’t apply)

Individual outpatient substance use disorder evaluation and treatment

You Pay
Individual outpatient substance use disorder evaluation and treatment
$20 per visit (Plan Deductible doesn’t apply)

Group outpatient substance use disorder treatment ...................................

You Pay
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) ..............

You Pay
Home health care (up to 100 visits per Accumulation Period) ..............
No charge (Plan Deductible doesn’t apply)

Other
Skilled nursing facility care (up to 100 days per benefit period) ..........

You Pay
Skilled nursing facility care (up to 100 days per benefit period) ........
10% Coinsurance (Plan Deductible doesn’t apply)

Prosthetic and orthotic devices as described in the EOC ......................

You Pay
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

You Pay
Diagnosis and treatment of infertility and artificial insemination (such

as outpatient procedures or laboratory tests) as described in the
as outpatient procedures or laboratory tests) as described in the
EOC ..............................................................................................................

see EOC for Cost Share

Assisted reproductive technology (“ART”) Services ..............................

You Pay
Assisted reproductive technology (“ART”) Services ..............................
Not covered

Hospice care ...............................................................................................

You Pay
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).