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 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.

<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>$1,500</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Drug Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
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</tbody>
</table>

Plan Provider Office Visits
You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits $20 per visit
Most Physician Specialist Visits $20 per visit
Routine physical maintenance exams, including well-woman exams No charge
Well-child preventive exams (through age 23 months) No charge
Scheduled prenatal care exams No charge
Routine eye exams with a Plan Optometrist No charge
Urgent care consultations, evaluations, and treatment $20 per visit
Most physical, occupational, and speech therapy $20 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
Primary Care Visits and Non-Physician Specialist Visits by telephone No charge
Physician Specialist Visits by telephone No charge

Outpatient Services
You Pay
Outpatient surgery and certain other outpatient procedures $20 per procedure
Most immunizations (including the vaccine) No charge
Most X-rays and laboratory tests No charge

Hospitalization Services
You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs $500 per admission

Emergency Health Coverage
You Pay
Emergency Department visits $125 per visit
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 $75 per trip

Prescription Drug Coverage
You Pay
Covered outpatient items in accord with our drug formulary guidelines:
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service $10 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service $25 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy $35 for up to a 30-day supply

Durable Medical Equipment (DME)
You Pay
DME items as described in the EOC 20% Coinsurance

Mental Health Services
You Pay
Inpatient psychiatric hospitalization $500 per admission
Individual outpatient mental health evaluation and treatment $20 per visit

(continues)
<table>
<thead>
<tr>
<th>Disclosure Form Part One</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Mental Health Services</strong></td>
<td><strong>You Pay</strong></td>
</tr>
<tr>
<td>Group outpatient mental health treatment</td>
<td>$10 per visit</td>
</tr>
<tr>
<td><strong>Substance Use Disorder Treatment</strong></td>
<td><strong>You Pay</strong></td>
</tr>
<tr>
<td>Inpatient detoxification</td>
<td>$500 per admission</td>
</tr>
<tr>
<td>Individual outpatient substance use disorder evaluation and treatment</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Group outpatient substance use disorder treatment</td>
<td>$5 per visit</td>
</tr>
<tr>
<td><strong>Home Health Services</strong></td>
<td><strong>You Pay</strong></td>
</tr>
<tr>
<td>Home health care (up to 100 visits per Accumulation Period)</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td><strong>You Pay</strong></td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per benefit period)</td>
<td>No charge</td>
</tr>
<tr>
<td>Prosthetic and orthotic devices as described in the <em>EOC</em></td>
<td>No charge</td>
</tr>
<tr>
<td>Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <em>EOC</em></td>
<td>the Cost Share you would pay if the Services were to treat any other condition</td>
</tr>
<tr>
<td>Assisted reproductive technology (“ART”) Services</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospice care</td>
<td>No charge</td>
</tr>
</tbody>
</table>

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).