Disclosure Form Part One

29560 UNIVERSITY OF SAN FRANCISCO
Home Region: Northern California
1/1/22 through 12/31/22

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>
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</thead>
<tbody>
<tr>
<td>Plan Out-of-Pocket Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$3,000</td>
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<tr>
<td>Plan Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Drug Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
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</tbody>
</table>

Professional Services (Plan Provider office visits)
You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits .................................. $15 per visit
Most Physician Specialist Visits ........................................................................................ $15 per visit
Routine physical maintenance exams, including well-woman exams .................................. No charge
Well-child preventive exams (through age 23 months) ........................................................ No charge
Family planning counseling and consultations ...................................................................... No charge
Scheduled prenatal care exams ............................................................................................. No charge
Routine eye exams with a Plan Optometrist .......................................................................... No charge
Urgent care consultations, evaluations, and treatment ......................................................... $15 per visit
Most physical, occupational, and speech therapy ............................................................... $15 per visit

Outpatient Services
You Pay

Outpatient surgery and certain other outpatient procedures .............................................. $15 per procedure
Allergy antigens (including administration) ........................................................................ $3 per visit
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 ...................... No charge

Emergency Health Coverage
You Pay

Emergency Department visits ............................................................................................. $50 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 ............................................................................................................... $50 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 ................................. $20 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy ...................................................................... $20 for up to a 30-day supply

DME items as described in the EOC .................................................................................. 20% Coinsurance

Mental Health Services
You Pay

Inpatient psychiatric hospitalization ..................................................................................... No charge
Individual outpatient mental health evaluation and treatment ........................................ $15 per visit
Group outpatient mental health treatment .......................................................................... $7 per visit

Substance Use Disorder Treatment
You Pay

Inpatient detoxification ........................................................................................................ No charge
Individual outpatient substance use disorder evaluation and treatment ......................... $15 per visit
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

(continues)
Other | You Pay
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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-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).