

Disclosure Form Part One

48023 SANTEN, INC.
Home Region: Northern California
1/1/23 through 12/31/23

Principal benefits for Kaiser Permanente HSA-Qualified High Deductible Health Plan (“HDHP”) HMO

“Kaiser Permanente HSA-Qualified High Deductible Health Plan (“HDHP”) HMO” is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the EOC.

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.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	\$3,000	\$3,000	\$6,000
Plan Deductible	\$3,000	\$3,000	\$6,000
Drug Deductible	Not applicable	Not applicable	Not applicable

Plan Provider Office Visits

Most Primary Care Visits and most Non-Physician Specialist Visits.....

Most Physician Specialist Visits

Routine physical maintenance exams, including well-woman exams

Well-child preventive exams (through age 23 months)

Scheduled prenatal care exams.....

Routine eye exams with a Plan Optometrist

Urgent care consultations, evaluations, and treatment

Most physical, occupational, and speech therapy.....

You Pay

No charge after Plan Deductible

No charge after Plan Deductible

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 after Plan Deductible

No charge after Plan Deductible

Telehealth Visits

Primary Care Visits and Non-Physician Specialist Visits by interactive video.....

Physician Specialist Visits by interactive video

Primary Care Visits and Non-Physician Specialist Visits by telephone..

Physician Specialist Visits by telephone

You Pay

No charge after Plan Deductible

No charge after Plan Deductible

No charge after Plan Deductible

No charge after Plan Deductible

Outpatient Services

Outpatient surgery and certain other outpatient procedures.....

Most immunizations (including the vaccine).....

Most X-rays and laboratory tests.....

Preventive X-rays, screenings, and laboratory tests as described in the EOC

You Pay

No charge after Plan Deductible

No charge (Plan Deductible doesn't apply)

No charge after Plan Deductible

No charge (Plan Deductible doesn't apply)

Hospitalization Services

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....

You Pay

No charge after Plan Deductible

Emergency Health Coverage

Emergency Department visits

You Pay

No charge 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

Ambulance Services.....

You Pay

No charge after Plan Deductible

Prescription Drug Coverage

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.....

You Pay

No charge for up to a 100-day supply after Plan Deductible

(continues)

Disclosure Form Part One*(continued)***Prescription Drug Coverage****You Pay**

Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	No charge for up to a 100-day supply after Plan Deductible
Most specialty items (Tier 4) at a Plan Pharmacy	No charge for up to a 30-day supply after Plan Deductible

Durable Medical Equipment (DME)**You Pay**

Base DME items as described in the <i>EOC</i>	No charge after Plan Deductible
Supplemental DME items up to a \$2,500 benefit limit per Accumulation Period as described in the <i>EOC</i>	No charge after Plan Deductible

Mental Health Services**You Pay**

Inpatient psychiatric hospitalization.....	No charge after Plan Deductible
Individual outpatient mental health evaluation and treatment	No charge after Plan Deductible
Group outpatient mental health treatment.....	No charge after Plan Deductible

Substance Use Disorder Treatment**You Pay**

Inpatient detoxification.....	No charge after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	No charge after Plan Deductible
Group outpatient substance use disorder treatment	No charge after Plan Deductible

Home Health Services**You Pay**

Home health care (up to 100 visits per Accumulation Period)	No charge after Plan Deductible
---	---------------------------------

Other**You Pay**

Skilled nursing facility care (up to 100 days per benefit period).....	No charge after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge after Plan Deductible
Diagnosis and treatment of infertility and artificial insemination.....	Not covered
Assisted reproductive technology ("ART") Services.....	Not covered
Hospice care	No charge after Plan Deductible

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).