**Disclosure Form**

600009 CALIFORNIA STATE UNIVERSITY FRESNO FOU
Home Region: Northern California

# Principal benefits for Kaiser Permanente Traditional Plan

(7/1/17—6/30/18)

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Contact Center.

**Accumulation Period**

The Accumulation Period for this plan is 1/1/17 through 12/31/17 (calendar year).

**Out-of-Pocket Maximum(s) and Deductible(s)**

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.

| 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 | $1,500 | $1,500 | $3,000 |
| Plan Deductible | None | None | None |
| Drug Deductible | None | None | None |

| Professional Services (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 |
| 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 | $20 per visit |
| Most physical, occupational, and speech therapy | $20 per visit |

| Outpatient Services | You Pay |
|---|---|
| Outpatient surgery and certain other outpatient procedures | $100 per procedure |
| Allergy injections (including allergy serum) | $5 per visit |
| Most immunizations (including the vaccine) | No charge |
| Most X-rays and laboratory tests | $10 per encounter |
| Preventive X-rays, screenings, and laboratory tests as described in the *EOC* | No charge |
| MRI, most CT, and PET scans | $50 per procedure |
| Covered individual health education counseling | No charge |
| Covered health education programs | 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 | $100 per visit |

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

| Ambulance Services | You Pay |
|---|---|
| Ambulance Services | $100 per trip |

| Prescription Drug Coverage | You Pay |
|---|---|
| Covered outpatient items in accord with our drug formulary guidelines: | |
| Most generic items at a Plan Pharmacy | $10 for up to a 30-day supply |
| Most generic refills through our mail-order service | $20 for up to a 100-day supply |
| Most brand-name items at a Plan Pharmacy | $30 for up to a 30-day supply |
| Most brand-name refills through our mail-order service | $60 for up to a 100-day supply |
| Most specialty items at a Plan Pharmacy | $30 for up to a 30-day supply |

| Durable Medical Equipment (DME) | You Pay |
|---|---|
| DME items in accord with our DME formulary guidelines | 20% Coinsurance |

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

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## Disclosure Form

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|---|---|
| Group outpatient mental health treatment | $10 per visit |

| **Chemical Dependency Services** | **You Pay** |
|---|---|
| Inpatient detoxification | $500 per admission |
| Individual outpatient chemical dependency evaluation and treatment | $20 per visit |
| Group outpatient chemical dependency treatment | $5 per visit |

| **Home Health Services** | **You Pay** |
|---|---|
| Home health care (up to 100 visits per Accumulation Period) | No charge |

| **Other** | **You Pay** |
|---|---|
| Skilled nursing facility care (up to 100 days per benefit period) | No charge |
| Prosthetic and orthotic devices | No charge |
| All Services related to covered infertility treatment | 50% Coinsurance |
| 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).