
Disclosure Form

Corona/Norco School District
Customer ID 231607
Member Services 1-800-464-4000

**Principal benefits for
Kaiser Permanente Traditional Plan**

(1/1/17—12/31/17)

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 (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	\$30 per visit
Most Physician Specialist Visits	\$30 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
Hearing exams	No charge
Urgent care consultations, evaluations, and treatment	\$30 per visit
Most physical, occupational, and speech therapy	\$30 per visit

Outpatient Services**You Pay**

Outpatient surgery and certain other outpatient procedures	\$30 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
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	No charge
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Emergency Health Coverage**You Pay**

Emergency Department visits	\$100 per visit
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Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services**You Pay**

Ambulance Services	\$150 per trip
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Prescription Drug Coverage**You Pay**

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items at a Plan Pharmacy	\$15 for up to a 30-day supply
Most generic refills through our mail-order service	\$30 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
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Mental Health Services**You Pay**

Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	\$30 per visit
Group outpatient mental health treatment	\$15 per visit

(continues)

Disclosure Form*(continued)***Chemical Dependency Services****You Pay**

Inpatient detoxification.....	No charge
Individual outpatient chemical dependency evaluation and treatment.....	\$30 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
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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).