Disclosed Form
979 Santa Clara University

Principal benefits for
Kaiser Permanente Traditional Plan
(1/13—12/31/13)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the Evidence of Coverage (EOC) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services.

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 Call Center.

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

- For self-only enrollment (a Family of one Member) ....................................................... $3,000 per calendar year
- For any one Member in a Family of two or more Members ........................................... $3,000 per calendar year
- For an entire Family of two or more Members .............................................................. $6,000 per calendar year

Deductible

None

Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

- Most primary and specialty care consultations, exams, and treatment ........................................ $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 and first postpartum follow-up consultation and exam ........... No charge
- Eye exams for refraction ................................................................................................. No charge
- Hearing exams .............................................................................................................. No charge
- Urgent care consultations, exams, and treatment ......................................................... $30 per visit
- Physical, occupational, and speech therapy ................................................................... $30 per visit

Outpatient Services

You Pay

- Outpatient surgery and certain other outpatient procedures ........................................... $250 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

Health education:
- 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 day

Emergency Health Coverage

You Pay

- Emergency Department visits ................................................................................... $150 per visit

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

Ambulance Services

You Pay

- Ambulance Services ................................................................................................. $150 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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply
  - Most generic refills through our mail-order service ................................................ $10 for up to a 30-day supply or $20 for a 31- to 100-day supply

(continues)
Most brand-name items at a Plan Pharmacy ................................................................. $30 for up to a 30-day supply, $60 for a 31- to 60-day supply, or $90 for a 61- to 100-day supply

Most brand-name refills through our mail-order service ................................................ $30 for up to a 30-day supply or $60 for a 31- to 100-day supply

<table>
<thead>
<tr>
<th><strong>Durable Medical Equipment</strong></th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines</td>
<td>50% Coinsurance</td>
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<table>
<thead>
<tr>
<th><strong>Mental Health Services</strong></th>
<th>You Pay</th>
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<tbody>
<tr>
<td>Inpatient psychiatric hospitalization</td>
<td>$500 per day</td>
</tr>
<tr>
<td>Individual outpatient mental health evaluation and treatment</td>
<td>$30 per visit</td>
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<tr>
<td>Group outpatient mental health treatment</td>
<td>$15 per visit</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Chemical Dependency Services</strong></th>
<th>You Pay</th>
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<tbody>
<tr>
<td>Inpatient detoxification</td>
<td>$500 per day</td>
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<tr>
<td>Individual outpatient chemical dependency evaluation and treatment</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>Group outpatient chemical dependency treatment</td>
<td>$5 per visit</td>
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<table>
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<tr>
<th><strong>Home Health Services</strong></th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (up to 100 visits per calendar year)</td>
<td>No charge</td>
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<tr>
<th><strong>Other</strong></th>
<th>You Pay</th>
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<tbody>
<tr>
<td>Eyewear purchased at Plan Medical Offices or plan optical sales offices every 24 months</td>
<td>Amount in excess of $175 Allowance</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per benefit period)</td>
<td>No charge</td>
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<tr>
<td>Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies</td>
<td>No charge</td>
</tr>
<tr>
<td>All Services related to covered infertility treatment</td>
<td>50% Coinsurance</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 Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).