2022-2023	Kaiser	Kaiser	Kaiser	Kaiser
	Trad HMO $10	Ded HMO $500	HSA-A Single	HSA-A Family
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0	$500/ $1,000	$1,500*	$2,800/ $3,000*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,500/$3,000	$3,000/$6,000	$3,000*	$3,000/$6,000*
			*Includes Rx	*Includes Rx
PROFESSIONAL SERVICES				
Office Visit (OV) co-pay ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$10	$20	Deductible, then 10%	Deductible, then 10%
Urgent Care co-pay	$10	$20	10%	10%
Specialists/Consultants co-pay	$10	$20	10%	10%
Prenatal, postnatal office visit co-pay	$0	$0	$0	$0
Scans: CT, CAT, MRI, PET etc.	$0	10% Copay up to $50	10%	10%
Diagnostic X-ray & Laboratory Procedures	$0	$10	10%	10%
Infertility (Refer to Plan Document)	Co-pay applies	Co-pay applies	Co-pay applies	Co-pay applies
Preventive Care (includes physical exams & screenings)	$0	0% Ded Waived	0% Ded Waived	0% Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES				
Emergency Room visit (copay waived if admitted)	$100	10%	10%	10%
Inpatient Hospital (preauthorization required) - limits may apply	$0	10%	10%	10%
Outpatient Hospital	$10	10%	10%	10%
Surgery, Outpatient (performed in Surgery Center)	$10	10%	10%	10%
Surgery, Outpatient (performed in a Hospital) - limits may apply	$10	10%	10%	10%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT				
INPATIENT: Facility Based Care (preauth required)	$0	10%	10%	10%
OUTPATIENT: Facility Based Care (preauth required)	$10	10%	10%	10%
OTHER SERVICES				
Ambulance (Ground or Air)	$50	$150	10%	10%

	Trad HMO $10	Ded HMO $500	HSA-A Single	HSA-A Family
Acupuncture - Limits apply	$10/30 visits (through ASH) combined w/chiro	$10/30 visits (through ASH) combined w/chiro	Requires Prior Authorization	Requires Prior Authorization
Chiropractic - Limits apply	$10/30 visits (through ASH) combined w/acu	$10/30 visits (through ASH) combined w/acu	no coverage	no coverage
Durable Medical Equipment (DME)	no charge	20%	10%	10%
Physical and Occupational Therapy - Limits apply	$10	$20	10%	10%
Hearing Aids	amount in excess of $500 allowance every 36 months	amount in excess of $500 allowance every 36 months	no coverage	no coverage

PHARMACY BENEFITS

Plan	Trad HMO $10	Ded HMO $500	HSA A	HSA A
Pharmacy Benefit Manager	Kaiser	Kaiser	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	none	Included w/ Medical ded	Included w/ Medical ded
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max
Generic co-pay/30 days supply	$10 up to 100 day supply	$10.00	deductible, then $10	deductible, then $10
Brand co-pay/30 days supply	$10 up to 100 day supply	$30.00	deductible, then $30	deductible, then $30
Specialty co-pay/up to 30 days supply	$10 up to 30 day supply	$30.00	deductible, then $30	deductible, then $30
Mail Order (Generic-Brand co-pay/90 days supply)	$10-$10/up to 100 day supply	$20-$60/up to 100 day supply	$20-$60/up to 100 day supply	$20-$60/up to 100 day supply
Mail Order Pharmacy	Kaiser Mail Order Pharmacy	Kaiser Mail Order Pharmacy	Kaiser Mail Order Pharmacy	Kaiser Mail Order Pharmacy

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the

*Coverage stages apply, see benefit summary for details