Medical Plan Comparison 2020-2021

Monthly Employee Premium	Kaiser HMO Employee Only \$97.57 Employee+1 \$390.26 Family \$546.37	Kaiser Added Choice Plan Employee Only \$128.50 Employee+1 \$514.01 Family \$719.62			Kaiser HDHP Plan Employee Only \$107.86 Employee+1 \$431.43 Family \$604.01		
	In-Network Only	Tier 1 HMO-Network	Tier 2 First Choice PPO	Tier 3 Out-of-Network	Tier 1 HMO-Network	Tier 2 First Choice PPO	Tier 3 Out-of-Network
Annual Deductible	None	Individual \$750 Family \$2,250	Individual \$1,000 Family \$3,000	Individual \$3,000 Family \$9,000	Individual \$1,500 Family \$3,000	Individual \$2,500 Family \$5,000	Individual \$3,500 Family \$7,000
Annual Out-of- Pocket Max	Individual \$1,250 Family \$2,500	Individual \$2,250 Family \$4,500	Individual \$3,000 Family \$9,000	Individual \$6,000 Family \$12,000	Individual \$2,500 Family \$5,000	Individual \$4,000 Family \$7,350	Individual \$5,000 Family \$10,000
Primary Care	\$15 Copay	\$15 Copay*	\$25 Copay*	40%	10% after deductible	20% after deductible	30% after deductible
Specialty Care	\$15 Copay	\$35 Copay*	\$50 Copay*	40%	10% after deductible	20% after deductible	30% after deductible
Diagnostic Lab & X-ray	No Charge	\$15 Copay*	20%*	40%	10% after deductible	20% after deductible	30% after deductible
Inpatient Stay/Surgery	\$250 per admission	10%	20%	40%	10% after deductible	20% after deductible	30% after deductible
Outpatient Surgery	\$15 Copay	10%	20%	40%	10% after deductible	20% after deductible	30% after deductible
Urgent Care	\$35 Copay	\$35 Copay*	\$50 Copay*	40%	10% after deductible	20% after deductible	30% after deductible

	Kaiser HMO	Kaiser Added Choice Plan			Kaiser HDHP Plan			
Emergency Room	\$75 Copay (waived if admitted)	\$250 Copay*			10% after deductible			
Ambulance Services	\$75 Copay	10%			10% after deductible			
Alternative Care*	\$1,500 Max / Calendar Year	\$1,500 Max / Calendar Year			\$1,500 Max / Calendar Year			
	\$15 Copay Chiropractic, Acupuncture & Naturopath	\$15 Copay Chir	ropractic, Acupunctu	-	\$15 Copay Chiropractic, Acupuncture & Naturopath \$25 Copay Massage			
	\$25 Copay Massage (massage max is 12 per year)	\$25 Copay Massage (massage max is 12 per year)			(massage max is 12 per year) ** all copays are after deductible has been paid **			
Prescription Retail (up to 30-day supply)	\$15 Generic \$30 Preferred \$50 Non-Preferred	\$15 Generic* \$30 Preferred* \$50 Non- Preferred*	At MedImpact Pharmacy: \$20 Generic* \$40 Preferred* \$60 Non-Preferred*		\$15 Generic \$30 Preferred \$50 Non-Preferred after deductible	At MedImpact Pharmacy: \$20 Generic \$40 Preferred \$60 Non-Preferred after deductible		
Mail Order Rx (up to 90-day supply)	2 x Retail	2 x Retail*	MedImpact Mail-Order call CVS 1-800-237-2767 kp.org/addedchoice		2 x Retail after deductible	MedImpact Mail-Order call CVS 1-800-237-2767 kp.org/addedchoice		
Vision Benefits (adult)	\$15 Exam Copay Up to \$150 Hardware allowance every 24 months.	\$15 Exam Copay* \$250 Hardware allowance per calendar year maximum benefit.	\$25 Exam Copay* \$250 Hardware allowance per calendar year maximum benefit.	40% Exam Coinsurance \$250 Hardware allowance per calendar year maximum benefit.	10% after deductible \$250 Hardware allowance per calendar year maximum benefit*	20% after deductible \$250 Hardware allowance per calendar year maximum benefit*	30% after deductible \$250 Hardware allowance per calendar year maximum benefit*	

Please note: This summary provides a brief description of the Plan benefits. It is not meant to address all covered services, nor does it address all limitations, exclusions, or instances where prior authorization may be required.

Please refer to the Summary Plan Document as it is the binding contract in the event of a discrepancy.

* Deductible Waived