Medical Plan Comparison - 2021/2022

Plan	Kaiser Value HMO	Kaiser Traditional HMO	Kaiser Added Choice (POS) Plan			Kaiser Added Choice HDHP Plan		
Employee Monthly Cost	Employee only: $49.50	Employee only: $100.44	Employee only: $130.36			Employee only: $111.64		
	Employee + Spouse/DP: $301.79	Employee + Spouse/DP: $401.74	Employee + Spouse/Domestic Partner: $521.47			Employee + Spouse/Domestic Partner: $446.54		
	Employee + Child(ren): $271.61	Employee + Child(ren): $361.58	Employee + 1 or more child(ren): $469.33			Employee + 1 or more child(ren): $401.89		
	Family: $452.69	Family: $602.62	Family: $782.21			Family: $669.81		
Network	**Kaiser HMO**	**Kaiser HMO**	**Kaiser HMO**	**First Choice/First Health**	**Out-of-Network**	**Kaiser HMO**	**First Choice/First Health**	**Out-of-Network**
Provider Tier	**In-Network Only**	**In-Network Only**	**In-Network Only**	**PPO Providers**	**Non-par Providers**	**In-Network Only**	**PPO Providers**	**Non-par Providers**
Annual Deductible	**Individual:** $750 **Family:** $2,250	**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 Maximum	**Individual:** $3,250 **Family:** $9,750	**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
Benefits								
Preventive Care	**Covered in full**	**Covered in full**	**Covered in full***	**Covered in full***	**40% co-insurance**, after deductible	**Covered in full***	**Covered in full***	**30% co-insurance**, after deductible
Tele-health	**Covered in full**	**Covered in full**	**Covered in full***	**Covered in full***	**40% co-insurance**, after deductible	**Covered in full**, after deductible	**Covered in full**, after deductible	**30% co-insurance**, after deductible
Primary Care	**$20 Copay***	**$15 Copay**	**$15 Copay***	**$25 Copay***	**40% co-insurance**, after deductible	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**30% co-insurance**, after deductible
Specialty Care	**$30 Copay***	**$15 Copay**	**$35 Copay***	**$50 Copay***	**40% co-insurance**, after deductible	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**30% co-insurance**, after deductible
Diagnostic Lab & X-ray	**$20 Copay***	**Covered in full**	**$15 Copay***	**20% co-insurance***	**40% co-insurance**, after deductible	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**30% co-insurance**, after deductible
Major Imaging	**$100 copay per dept***	**Covered in full**	**$100 copay per dept***	**20% co-insurance**, after deductible	**40% co-insurance**, after deductible	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**30% co-insurance**, after deductible
Outpatient Surgery	**20% co-insurance**, after deductible	**$15 Copay**	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**40% co-insurance**, after deductible	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**30% co-insurance**, after deductible
Inpatient Stay/Surgery	**20% co-insurance**, after deductible	**$250 per admission**	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**40% co-insurance**, after deductible	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**30% co-insurance**, after deductible
Urgent Care	**$40 Copay***	**$35 Copay**	**$35 Copay***	**$50 Copay***	**40% co-insurance**, after deductible	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**30% co-insurance**, after deductible
Emergency Room	**20% co-insurance**, after deductible	**$75 Copay** (waived if admitted)	**$250 Copay***			**10% co-insurance**, after deductible		
Alternative Care								
Annual Benefit Maximum	**$1,500 Combined Benefits**	**$1,500 Combined Benefits**	**$1,500 Combined Benefits**			**$1,500 Combined Benefits**		
Acupuncture, Chiro & Naturopath	**$20 copay***	**$15 copay**	**$15 copay***			**$15 copay**, after deductible has been met		
Massage Therapy	**$25 copay*** (12 visit limit per year)	**$25 copay** (12 visit limit per year)	**$25 copay*** (12 visit limit per year)			**$25 copay**, after deductible has been met (12 visit limit per year)		
Adult Vision Benefits								
Annual Exam	**$20 copay***	**$15 copay**	**$15 Copay***	**$25 Copay***	**40% co-insurance**, after deductible	**10% co-insurance**, after deductible	**20% co-insurance**, after deductible	**30% co-insurance**, after deductible
Hardware	**$150 allowance**, covered every 24 months	**$150 allowance**, covered every 24 months	**$250 allowance**, once per calendar year	**$250 allowance**, once per calendar year	**$250 allowance**, once per calendar year	**$250 allowance**, once per calendar year	**$250 allowance**, once per calendar year	**$250 allowance**, once per calendar year
Prescription Drugs	**Retail Pharmacy**	**Retail Pharmacy**	**Retail Pharmacy**	**MedImpact Pharmacy only**		**Retail Pharmacy**	**Medimpact Pharmacy only**	
Annual Deductible	**Waived**	**Waived**	**Waived**	**Waived**		**Medical deductible applies**	**Medical deductible applies**	
Generic	**$15 copay**	**$15 copay**	**$15 copay***	**$20 copay**		**$15 copay**	**$20 copay**	
Preferred	**$30 copay**	**$30 copay**	**$30 copay***	**$40 copay**		**$30 copay**	**$40 copay**	
Non-preferred	**$50 copay**	**$50 copay**	**$50 copay***	**$60 copay**		**$50 copay**	**$60 copay**	
Mail Order Rx	**2 copays for 90 days**	**2 copays for 90 days**	**2 copays for 90 days**	**MedImpact Mail-Order** [Call CVS at 1-800-237-2767 or visit kp.org/addedchoice]		**2 copays for 90 days**	**MedImpact Mail-Order** [Call CVS at 1-800-237-2767 or visit kp.org/addedchoice]	

*** If noted with an (*), the Medical Deductible does not apply**

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.