KAISER PERMANENTE®

AURORA PUBLIC SCHOOLS – MEDICAL PLAN OVERVIEW (July 1, 2018 – June 30, 2019)

BENEFIT	Kaiser Permanente DHMO 1000	Kaiser Permanente DHMO 2500	Kaiser Permanente HDHP 1500	Kaiser Permanente HDHP 3000	Kaiser Permanente Point-of-Service (POS)		
					Kaiser Permanente DHMO (Tier 1)	Kaiser Permanente PHCS Network (Tier 2) www.MultiPlan.com/Kaiser	Out-of-Network (Tier 3)
Deductible							
Individual	$1,000 (Embedded)	$2,500 (Embedded)	$1,500 (Aggregate)	$3,000 (Embedded)	$1,000 (Embedded)	$2,000 (Embedded)	$5,000 (Embedded)
Family	$3,000 (Embedded)	$7,500 (Embedded)	$3,000 (Aggregate)	$6,000 (Embedded)	$3,000 (Embedded)	$6,000 (Embedded)	$15,000 (Embedded)
Out-of-Pocket Maximum	Includes Deductible	Includes Deductible	Includes Deductible	Includes Deductible	Includes Deductible	Includes Deductible	Includes Deductible
Individual	$4,000 (Embedded)	$4,000 (Embedded)	$4,000 (Aggregate)	$5,000 (Embedded)	$3,000 (Embedded)	$3,500 (Embedded)	$16,000 (Embedded)
Family	$9,000 (Embedded)	$9,000 (Embedded)	$6,850 (Aggregate)	$10,000 (Embedded)	$6,000 (Embedded)	$7,000 (Embedded)	$48,000 (Embedded)
Routine OVC	$25 Copay(1)	$25 Copay(1)	10% Coinsurance after deductible	20% Coinsurance after deductible	$25 Copay(1)	$35 Copay(1)	50% Coinsurance after deductible
Specialty OVC	$50 Copay(1)	$25 Copay(1)	10% Coinsurance after deductible	20% Coinsurance after deductible	$40 Copay(1)	$50 Copay(1)	50% Coinsurance after deductible
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	$70 Copay
Maternity							
Prenatal Care	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient/Delivery	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Prescription Drugs			Prescription Drugs are subject to the Deductible	Prescription Drugs are subject to the Deductible			
Generic	Retail: $15 copay, 30-day supply Mail Order: $30 copay, 90-day supply	Retail: $15 copay, 30-day supply Mail Order: $30 copay, 90-day supply	Retail: $20 copay, 30-day supply Mail Order: $40 copay, 90-day supply	Retail: $20 copay, 30-day supply Mail Order: $40 copay, 90-day supply	Retail: $15 copay, 30-day supply Mail Order: $30 copay, 90-day supply	Retail: $25 copay, 30-day supply Mail Order: $50 copay, 90-day supply	Retail: 50% Coinsurance after deductible, 30-day supply
Brand	Retail: $30 copay, 30-day supply Mail Order: $60 copay, 90-day supply	Retail: $30 copay, 30-day supply Mail Order: $60 copay, 90-day supply	Retail: $40 copay, 30-day supply Mail Order: $80 copay, 90-day supply	Retail: $40 copay, 30-day supply Mail Order: $80 copay, 90-day supply	Retail: $30 copay, 30-day supply Mail Order: $60 copay, 90-day supply	Retail: $40 copay, 30-day supply Mail Order: $80 copay, 90-day supply	Retail: 50% Coinsurance after deductible, 30-day supply
Non-Preferred	Retail: $50 copay, 30-day supply Mail Order: $100 copay, 90-day supply	Retail: $50 copay, 30-day supply Mail Order: $100 copay, 90-day supply	Retail: $60 copay, 30-day supply Mail Order: $120 copay, 90-day supply	Retail: $60 copay, 30-day supply Mail Order: $120 copay, 90-day supply	Retail: 50% Coinsurance, 30-day supply Mail Order: 50% Coinsurance, 90-day supply	Retail: 50% Coinsurance, 30-day supply Mail Order: 50% Coinsurance, 90-day supply	Retail: 50% Coinsurance after deductible, 30-day supply
Specialty	20% coinsurance up to $75, 30-day supply	20% coinsurance up to $75, 30-day supply	20% Coinsurance after deductible	20% Coinsurance after deductible	20% coinsurance up to $75, 30-day supply	20% coinsurance up to $250, 30-day supply	50% Coinsurance after deductible, 30-day supply
Inpatient Hospital	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient / Ambulatory Care	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Laboratory	No Charge	No Charge	10% Coinsurance after deductible	20% Coinsurance after deductible	No Charge	20% Coinsurance after deductible	50% Coinsurance after deductible
X-Ray	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
MRI/CAT/PET	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Emergency Care	$250 Copay	$250 Copay	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible
Ambulance	10% Coinsurance up to $500/trip; Not subject to the Deductible	20% Coinsurance up to $500/trip; Not subject to the Deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance up to $500/trip; Not subject to the Deductible	10% Coinsurance up to $500/trip; Not subject to the Deductible	10% Coinsurance up to $500/trip; Not subject to the Deductible
Urgent Care	$50 Copay(1) (2)	$50 Copay(1) (2)	10% Coinsurance after deductible(2)	20% Coinsurance after deductible(2)	$50 Copay 10% Coinsurance(1) (2)	$50 Copay 10% Coinsurance(1)	$50 Copay 10% Coinsurance(1)
Mental Health							
Inpatient Hospital	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Care	$25 Copay(1)	$25 Copay(1)	10% Coinsurance after deductible	20% Coinsurance after deductible	$25 Copay(1)	$35 Copay(1)	50% Coinsurance after deductible
Alcohol & Substance Abuse							
Inpatient	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Care	$25 Copay(1)	$25 Copay(1)	10% Coinsurance after deductible	20% Coinsurance after deductible	$25 Copay(1)	$35 Copay(1)	50% Coinsurance after deductible
Physical, Occupational & Speech Therapy (Outpatient)	$25 Copay up to 20 visits per year per therapy	$25 Copay up to 20 visits per year per therapy	10% Coinsurance after deductible up to 20 visits per year per therapy	20% Coinsurance after deductible up to 20 visits per year per therapy	$25 Copay up to 20 visits per year per therapy	$35 Copay	50% Coinsurance after deductible
						Up to 20 visits per year per therapy in Tiers 2 and 3 combined	
Durable Medical Equipment	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	Covered in Plan Only	Covered in Plan Only
Oxygen	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	Covered in Plan Only	Covered in Plan Only
Organ Transplant	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	Covered in Plan Only	Covered in Plan Only
Home Health Care	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
						Up to 60 visits per year in Tiers 2 and 3 combined	
Hospice Care	No Charge	No Charge	10% Coinsurance after deductible	20% Coinsurance after deductible	No Charge	20% Coinsurance after deductible	50% Coinsurance after deductible
Skilled Nursing Facility	10% Coinsurance after deductible; 100 days per year	20% Coinsurance after deductible; 100 days per year	10% Coinsurance after deductible; 100 days per year	20% Coinsurance after deductible; 100 days per year	10% Coinsurance after deductible; 100 days per year	Covered in Plan Only	Covered in Plan Only
Vision Care	$25 Copay; exam only(1)	$25 Copay; exam only(1)	10% Coinsurance after deductible	20% Coinsurance after deductible	$25 Copay; exam only(1)	$35 Copay; exam only(1)	50% Coinsurance after deductible; exam only(1)
Chiropractic Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Exam	$25 Copay; exam only(1)	$25 Copay; exam only(1)	10% Coinsurance after deductible	20% Coinsurance after deductible	$25 Copay; exam only(1)	Not Covered; $35 Copay for minors, 20% Coinsurance for Hearing Aids for minors	Not Covered; 50% Coinsurance after deductible for Exams and Hearing Aids for minors

1) **Procedures received during an office visit are subject to the deductible and coinsurance.**
2) **Urgent Care is covered inside the service area within the Kaiser Permanente network. Please refer to your Evidence of Coverage for details on Urgent/Non-Routine/After Hours Care outside of the service area.**

***This document is for illustrative purposes only. Please refer to your Evidence of Coverage (EOC) and Certificate of Insurance (COI) for your coverage details.**