

## Clackamas Community College OEBB 2021-2022 Plan Year – Summary of Kaiser Medical and Pharmacy Benefits

Medical Plans - No lifetime maximum on any medical plans	Kaiser Medical Plan 1		Kaiser Medical Plan 2A		Kaiser Medical Plan 3 – HSA Optional	
Plan Year Costs – Deductibles and copayments apply to the annual out-of-pocket maximum	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Deductible per person	None	NA	\$800	N/A	\$1,600 <sup>2</sup>	A
Maximum deductible per family	None	NA	\$2,400	N/A	\$3,200 <sup>2</sup>	A
Out-of-pocket (OOP) maximum per person <sup>3</sup>	\$1,500	NA	\$4,000	N/A	\$6,550 <sup>2</sup>	A
Out-of-pocket (OOP) maximum per family <sup>3</sup>	\$3,000	NA	\$12,000	N/A	\$13,100 <sup>2</sup>	A
Maximum cost share per person	NA	NA	N/A	N/A	NA	A
Maximum cost share per family	NA	NA	N/A	N/A	NA	A
<b>Preventive Care Services</b>						
Wellness Visit	\$0	NA	\$0 <sup>1</sup>	N/A	\$0 <sup>1</sup>	A
Routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	\$0	Not covered	\$0 <sup>1</sup>	N/A	\$0 <sup>1</sup>	Not covered
<b>Office Visits and Virtual Care</b>						
Primary care office visits	\$20	Not covered	\$25 <sup>1</sup>	Not covered	20%	Not covered
Virtual Care	\$0	Not covered	\$0 <sup>1</sup>	Not covered	\$0	Not covered
Specialist office visits	\$30	Not covered	\$35 <sup>1</sup>	Not covered	20%	Not covered
Urgent care	\$35	See Plan Handbook	\$40 <sup>1</sup>	See Plan Handbook	20%	See Plan Handbook
<b>Mental Health Services</b>						
Mental health office visits	\$20	Not covered	\$25 <sup>1</sup>	Not covered	20%	Not covered
Mental health inpatient and residential services	\$100 per day, up to \$500 per admission max	Not covered	20%	Not covered	20%	Not covered
Chemical dependency services (inpatient, outpatient, or residential)	\$0	Not covered	\$0 <sup>1</sup>	Not covered	20%	Not covered
<b>Outpatient Services</b>						
Outpatient surgery/facility care	\$75	Not covered	20%	Not covered	20%	Not covered
Outpatient rehabilitation (physical, occupational & speech therapy) Maximum 20 visits per therapy per plan year	\$30 per visit	Not covered	\$35 <sup>1</sup>	Not covered	20%	Not covered
<b>Tests (outpatient)</b>						
Preventive tests	\$0	Not covered	\$0 <sup>1</sup>	Not covered	\$0 <sup>1</sup>	Not covered
Laboratory	\$20 per visit	Not covered	\$25 <sup>1</sup> per visit	Not covered	20%	Not covered
X-ray, imaging, and special diagnostic procedures	\$20 per visit	Not covered	\$25 <sup>1</sup> per visit	Not covered	20%	Not covered
CT, MRI, PET scans	\$20 per visit	Not covered	\$25 <sup>1</sup> per visit	Not covered	20%	Not covered
<b>Alternative Care Services<sup>8</sup></b>						
Acupuncture, chiropractic & naturopathic services <sup>11</sup>	\$20 per service	Not covered	\$25 <sup>1</sup> per service	Not covered	20%	Not covered
<b>Maternity Care</b>						
Outpatient maternity care	\$0	Not covered	\$0 <sup>1</sup>	Not covered	\$0 <sup>1</sup>	Not covered
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	\$100 per day, up to \$500 per admission max	Not covered	20%	Not covered	20%	Not covered
<b>Hospital Services</b>						
Inpatient care/surgery	\$100 per day, up to \$500 per admission max	See Plan Handbook	20%	See Plan Handbook	20%	See Plan Handbook
Skilled nursing facility care (100 days per plan year)	\$0	NA	20%	N/A	20%	NA
<b>Emergency Services</b>						
Emergency room	\$100 per visit (waived if admitted)		20%		20%	
Ambulance	\$75		\$100 <sup>1</sup>		20%	

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Other Covered Services						
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	Not covered	10% <sup>1</sup>	Not covered	20%	Not covered
Durable medical equipment (DME)	20%	Not covered	20% <sup>1</sup>	Not covered	20%	Not covered
Bariatric surgery	\$500 + Inpatient care cost	Not covered	\$500 + 20%	Not covered	\$500 + 20%	Not covered
Pharmacy Services						
Out-of-pocket (OOP) maximum	\$1100 – Rx max also applies to Medical OOP max		\$1100 – Rx max also applies to Medical OOP max		Rx applies toward plan OOP max	
Retail						
Generic	\$5 per 30-day supply	See Plan Handbook	\$5 per 30-day supply	See Plan Handbook	20%	See Plan Handbook
Preferred brand	\$25 per 30-day supply	See Plan Handbook	\$25 per 30-day supply	See Plan Handbook	20%	See Plan Handbook
Non-preferred brand <sup>5</sup>	\$45 per 30-day supply if criteria met	See Plan Handbook	\$45 per 30-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook
Mail						
Generic	\$10 per 90-day supply	See Plan Handbook	\$10 per 90-day supply	See Plan Handbook	20%	See Plan Handbook
Preferred brand	\$50 per 90-day supply	See Plan Handbook	\$50 per 90-day supply	See Plan Handbook	20%	See Plan Handbook
Non-preferred brand <sup>5</sup>	\$90 per 90-day supply if criteria met	See Plan Handbook	\$90 per 90-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook
Specialty						
Select generic	25% up to \$100 per 30-day supply	See Plan Handbook	25% up to \$100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook
Non-preferred brand <sup>5</sup>	25% up to \$100 per 30-day supply	See Plan Handbook	25% up to \$100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook

Plan Premium	Kaiser Medical Plan 1	Kaiser Medical Plan 2A	Kaiser Medical Plan 3 – HSA Optional
Employee Only	\$634.87	\$524.73	\$387.23
Employee + Spouse/Partner	\$1,396.71	\$1,155.14	\$852.41
Employee + Child(ren)	\$1,206.25	\$996.94	\$735.43
Employee + Family	\$1,968.10	\$1,627.46	\$1,200.65

The premiums listed above are not the amounts that you pay each month. Utilize the Monthly Benefits Calculator on the [HR Webpage](#) to calculate your monthly out-of-pocket cost.

N/A = Not applicable

<sup>1</sup> Deductible waived

<sup>2</sup> Individual deductibles and out-of-pocket (OOP) maximum apply to single coverage only. Family deductible and OOP maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member OOP maximum, which is set at the individual OOP maximum amount. Under this plan, deductible must be met before benefits will be paid (except where <sup>1</sup> indicates deductible waived).

<sup>5</sup> A formulary exception must be approved for non-preferred brand prescription medication.

<sup>7</sup> For value tier list please visit <https://my.kp.org/oebb/plans/> at bottom of page.

<sup>8</sup> For Kaiser plans, acupuncture care, spinal manipulation and naturopathic substance only accrue towards your \$2000 benefit maximum.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this document and your member handbook, the member handbook will prevail.