## Clackamas Community College OEBB 2022-2023 Plan Year – Summary of Kaiser Medical and Pharmacy Benefits

Plan Page Costs	Medical Plans - No lifetime maximum on any medical plans	Kaiser Me	edical Plan 1	Kaiser Medical Plan 2A		Kaiser Medical Plan 3 – HSA Optional		
Member Pays	Plan Year Costs	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Search   S				Member Pays	Member Pays	Member Pays	Member Pays	
State   Stat		,	<i>J</i>	,				
Substitute   Sub			NA		N/A		NA	
Preventive Gare Services			NA		N/A		NA	
Mode	Out-of-pocket (OOP) maximum per family <sup>3</sup>	\$3,000			N/A	\$13,100 <sup>2</sup>	NA	
Routine adult. well child and nomen's searms atmust deseily so centing and immunications. See Plan Handbook for additional Presentate Carie Services.    Primary Care of Disc visits   50   Not covered	Preventive Care Services							
Primary gaze office visits   See Plan Hardbook for additional Preventive Care Services   Salo   Not covered   S		\$0	NA	\$0 <sup>1</sup>	N/A	\$0 <sup>1</sup>	NA	
Primary pare office visits   \$20		\$0	Not covered	\$0 <sup>1</sup>	N/A	\$0 <sup>1</sup>	Not covered	
Virtual Care   S0   Not covered   S0   Not covered   S0   Not covered   S0   Not covered   20% after deductible   Not covered   10% after deductible   Not covered   20% after deductible   Not co			Office Visits and Vir	tual Care				
Special differ visits   Special part of the control of the part of the control of the part of the control of the part of the	Primary care office visits	\$20	Not covered	\$25 <sup>1</sup>	Not covered		Not covered	
Sop   March   Sop   Sop   March   Sop   Sop   March   Sop   March   Sop   March   Ma								
Mental Health Grize visits   \$20   Not covered   \$25   Not covered   20% after deductible   Not covered   20% after dedu								
Montan health inpatient and residential services   S20 per day, up to \$500 per admission max   Not covered   20% after deductible   Not covered   20% after d	Urgent care	\$35		•	See Plan Handbook	20% after deductible	See Plan Handbook	
Mental health inpatient and residential services   \$100 per day, up to \$500 per day,			Mental Health Se					
per admission max  Outpatient surgery/facility care  Outpatient rehabilitation (physical, occupational & speech therapy)  \$30 per visit  Not covered  \$75 Not covered  \$35' per visit  Not covered  \$35' per visit  Not covered  \$20% after deductible  Not covered  20% aft			Not covered	\$25 <sup>1</sup>	Not covered	20% after deductible	Not covered	
Outpatient Services  Not covered 20% after deductible Not 20% a	Mental health inpatient and residential services	\$100 per day, up to \$500 per admission max	Not covered	20% after deductible	Not covered		Not covered	
Outpatient surgen/flacitity care   \$75   Not covered   20% after deductible   Not c	Chemical dependency services (inpatient, outpatient, or residential)	\$0	Not covered	\$0 <sup>1</sup>	Not covered	20% after deductible	Not covered	
Subject of the abilitation (physical, occupational & speech therapy)			Outpatient Serv	ices				
Maximum 20 visits per therapy per plan year  Tests (outpatient)  Laboratory  \$20 per visit Not covered \$25' per visit Not covered \$25' per visit Not covered 20% after deductible Not covered CT, MRI, PET scans \$20 per visit Not covered \$25' per visit Not covered 20% after deductible Not covered CT, MRI, PET scans \$20 per visit Not covered \$25' per visit Not covered 20% after deductible Not covered CT, MRI, PET scans \$20 per visit Not covered \$25' per visit Not covered 20% after deductible Not covered CT, MRI, PET scans Alternative Care Services  Acupuncture, chiropractic & naturopathic services 1 \$20 per service Not covered \$25' per service Not covered 20% after deductible See Plan Handbook 20% after deductible See Plan Handbook 20% after deductible Not covered 20% after deductible Not covered 20% after deductible Not covered 20% after deductible Not		\$75	Not covered	20% after deductible	Not covered	20% after deductible	Not covered	
Laboratory \$20 per visit Not covered \$25 per visit Not covered \$25 per visit Not covered 20% after deductible Not covered \$7.00 per visit Not covered \$2.00 per visit Not covered \$2.00 per visit Not covered 20% after deductible Not 20% after deductibl		\$30 per visit	Not covered	\$351 per visit	Not covered	20% after deductible	Not covered	
Laboratory \$20 per visit Not covered \$25 per visit Not covered \$25 per visit Not covered 20% after deductible Not covered \$7.00 per visit Not covered \$2.00 per visit Not covered \$2.00 per visit Not covered 20% after deductible Not 20% after deductibl			Tests (outpatie	ent)				
CT, MRI, PET scans \$20 per visit Not covered \$25' per visit Not covered Alternative Care Services*  Alternative Care Services*  Acupuncture, chiropractic & naturopathic services¹¹ \$20 per service Not covered \$20' after deductible \$20' after ded	Laboratory	\$20 per visit			Not covered	20% after deductible	Not covered	
Actupuncture, chiropractic & naturopathic services 11 \$20 per service Not covered \$25 per service Not covered \$20% after deductible Not covered Not covered Physician or midwife services & hospital stay, delivery & routine newborn nursery care  Inpatient care/surgery  Skilled nursing facility care (100 days per plan year)  Emergency room  Stillo per visit (waived if admitted)  Ambulance  Alternative Care Services & Not covered \$20% after deductible Not covered 20% after deductible Not covered Not co		\$20 per visit	Not covered	\$25 <sup>1</sup> per visit	Not covered	20% after deductible	Not covered	
Acupuncture, chiropractic & naturopathic services 11 \$20 per service Not covered \$25 per service Not covered \$20% after deductible Not covered Not covered S01 Not covered \$01 Not covered \$01 Not covered S01 Not covered S03 Not covered S04 Not covered S05	CT, MRI, PET scans	\$20 per visit			Not covered	20% after deductible	Not covered	
Outpatient maternity care  Outpatient maternity care  Physician or midwife services & hospital stay, delivery & routine newborn unsery care  Inpatient care/surgery  Inpatient care/surgery  S100 per day, up to \$500 per admission max  Hospital Services  Hospital Services  Inpatient care/surgery  See Plan Handbook  See Plan Handbook  See Plan Handbook  20% after deductible  Not covered  See Plan Handbook  20% after deductible  Not covered  Not covered  Not covered  See Plan Handbook  20% after deductible  NA  20% after deductible  NA  Defraction in the covered in the cover			Alternative Care Se	ervices <sup>8</sup>				
Outpatient maternity care  Physician or midwife services & hospital stay, delivery & routine newborn nursery care  Inpatient care/surgery  Inpatient c	Acupuncture, chiropractic & naturopathic services <sup>11</sup>	\$20 per service	Not covered	\$25 <sup>1</sup> per service	Not covered	20% after deductible	Not covered	
Physician or midwife services & hospital stay, delivery & routine newborn nursery care  Hospital Services  Hospital Services  Inpatient care/surgery  Inpatient care/surgery  \$100 per day, up to \$500 per admission max  \$100 per day, up to \$500 per admission max  \$20% after deductible								
nursery care per admission max			Not covered	\$0 <sup>1</sup>	Not covered	\$0 <sup>1</sup>	Not covered	
Inpatient care/surgery Inpatient care/surgery Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Skilled nursing facility care (100 days per plan year)  Ske Plan Handbook  NA  20% after deductible  About color deductible  Ske Plan Handbook  NA  20% after deductible  Ske Plan Handbook  NA  Ske Plan Handbook  NA  20% after deductible  About color deductible  NA  Ske Plan Handbook  NA  Ske Plan Handbook  NA  20% after deductible  NA  20% after deductible  NA  20% after deductible  NA  About color deductible  NA  Not covered  NA  Ske Plan Handbook  NA  Ske Plan Handbook  NA  Ske Plan Handbook  NA  20% after deductible  NA  Ske Plan Handbook  NA  NA  Ske Plan Handbook  NA  Ske Plan			Not covered	20% after deductible	Not covered	20% after deductible	Not covered	
Skilled nursing facility care (100 days per plan year)  \$0 NA 20% after deductible N/A 20% after deductible NA  Emergency Services  Emergency room \$100 per visit (waived if admitted) 20% after deductible 20% after deductible 20% after deductible 30% after deduc			Hospital Servi	ces				
Emergency Foom \$100 per visit (waived if admitted) 20% after deductible 30% after deductible	Inpatient care/surgery		See Plan Handbook	20% after deductible	See Plan Handbook	20% after deductible	See Plan Handbook	
Emergency room \$100 per visit (waived if admitted) 20% after deductible	Skilled nursing facility care (100 days per plan year)	\$0	NA	20% after deductible	N/A	20% after deductible	NA	
Ambulance \$75 \$100¹ 20% after deductible  Other Covered Services  Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children  Not covered  10% Not covered  10% Not covered  20% after deductible Not covered Not covered			Emergency Serv	vices				
Ambulance \$75 \$100¹ 20% after deductible  Other Covered Services  Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children  Not covered  10% Not covered  10% Not covered  20% after deductible Not covered Not covered	Emergency room			20% after deductible				
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children  Not covered  Not covered  Not covered  20% after deductible  Not covered								
handbook for State mandated benefit for children	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%1	Not covered	20% after deductible	Not covered	
		20%	Not covered	20%1	Not covered	20% after deductible	Not covered	

## Clackamas Community College OEBB 2022-2023 Plan Year – Summary of Kaiser Medical and Pharmacy Benefits

Pharmacy Services							
Out-of-pocket (OOP) maximum	\$1100 – Rx max also app	olies 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% after deductible	See Plan Handbook	
Preferred brand	\$25 per 30-day supply	See Plan Handbook	\$25 per 30-day supply	See Plan Handbook	20% after deductible	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% after deductible	See Plan Handbook	
Mail			-				
Generic	\$10 per 90-day supply	See Plan Handbook	\$10 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook	
Preferred brand	\$50 per 90-day supply	See Plan Handbook	\$50 per 90-day supply	See Plan Handbook	20% after deductible	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% after deductible	See Plan Handbook	
Specialty	<u>-</u>						
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% after deductible	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% after deductible	See Plan Handbook	

Plan Premium	Kaiser Medical Plan 1	Kaiser Medical Plan 2A	Kaiser Medical Plan 3 – HSA Optional			
Employee Only	\$663.25	\$549.26	\$404.50			
Employee + Spouse/Partner	\$1,459.17	\$1,209.15	\$890.43			
Employee + Child(ren)	\$1,260.18	\$1,043.54	\$768.23			
Employee + Family	\$2,056.10	\$1,703.53	\$1,254.20			
The premiums listed above are not the amounts that you pay each month. Utilize the Monthly Renefits Calculator on the HR Wehnage to calculate your monthly out-of-pocket cost						

NA = Not applicable

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.

<sup>&</sup>lt;sup>1</sup> Deductible waived

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

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

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

<sup>&</sup>lt;sup>11</sup> For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year.