

# PLU's Medical Plan Options effective 1/1/2024

		Kaiser Permanente Access PPO	
<b>Providers</b>		<b>In-Network</b> Kaiser Permanente doctors and clinicians and contracted providers. See Kaiser website for locations and providers	<b>Out-of-Network</b> Any licensed provider
<b>Deductible</b> Deductible does not apply to preventive care, prescription drugs or vision exams/ hardware unless specified otherwise.		\$750/individual, \$1,500/family	\$1,500/individual, \$3,000/family
<b>Out-of-Pocket (OOP) Limit</b>		\$3,000/individual, \$6,000/family <b>Includes all cost shares for covered services (deductible, coinsurance &amp; copays)</b>	No Out-of-Pocket Limit
<b>Lifetime Maximum</b>		Unlimited	
<b>Office Calls (Visits)</b>		Deductible and coinsurance apply	
		No copay 90%	No copay 70%
<b>Hospitalization</b>		Deductible and coinsurance apply	
	Emergency Rm Copay	\$150 per visit, then 90% after deductible	
	Outpatient	90%	70%
	Inpatient	90%	70%
<b>Preventive Care</b>		Not subject to deductible or coinsurance 100%	<u>Deductible and Coinsurance apply</u> 70%
<b>Vision</b>		Not subject to deductible or coinsurance	
	Eye Exam	No copay 1 per 12 months, 100%	
	Hardware	Up to \$250 in 24-month period for age 19+; (for age 18 & under, see Summary for details)	Shared with preferred provider network (PPN)
<b>Manipulative Therapy (Chiropractic)</b>		Deductible and coinsurance apply	
		90%	70%
		15 visits per year	Visit limits shared with PPN
<b>Prescriptions</b>		IN-NETWORK ONLY - Not subject to deductible	
	Supply Amount	Retail (30-day supply)	Mail Order (90-day supply)
	Preferred Generic	\$15 copay (\$10 enhanced)	\$20 copay
	Preferred Brand	\$25 copay (\$20 enhanced)	\$40 copay
	Non-Preferred Generic/Brand	\$45 copay (\$40 enhanced)	\$80 copay
	Pharmacy	Kaiser pharmacy Any of OptumRx's national network of 65,000 pharmacies Discount for Preferred & Non-Preferred prescriptions: \$5 less when obtained at a Kaiser pharmacy	
<b>Hearing</b>		Deductible and coinsurance apply	
	Routine Exam	No copay	
	Hardware	\$3,000 per ear every 36 months	Benefit shared with PPN
<b>Other Benefits</b>		See Kaiser Summary of Benefits for details	
<b>Monthly Rates</b>		<b>Access PPO</b>	
		<b>Employee's contribution</b>	<b>PLU's contribution</b>
	<b>Employee Only</b>	\$75.00 (was \$64.00)	\$791.70 (was \$732.32)
	<b>Employee with a Spouse/DP</b>	\$892.00 (was \$792.00)	\$841.38 (was \$800.64)
	<b>Employee with Child(ren)</b>	\$484.00 (was \$430.00)	\$820.28 (was \$768.46)
	<b>Employee with Spouse/DP &amp; Child(ren)</b>	\$930.00 (was \$840.00)	\$820.46 (was \$768.40)

# PLU's Medical Plan Options effective 1/1/2024

		<b>Kaiser Permanente Virtual Plus Plan</b>	
<b>Providers</b>		<b>Connect Network</b> See Kaiser Permanente website for locations and providers	
<b>Deductible and Coinsurance</b>		\$500/individual \$1,000/family Plan pays 80%	
<b>Out-of-Pocket (OOP) Limit</b>		\$3,000/individual, \$6,000/family <b>Includes all cost shares for covered services (deductible, coinsurance &amp; copays)</b>	
<b>Lifetime Maximum</b>		Unlimited	
<b>Office Calls (Visits)</b>			
	Copay	\$20 primary / \$40 specialty	
	Authorized visits	<b>Not subject to deductible or coinsurance</b>	
	Self-directed or Non-authorized visits	<b>Subject to deductible or coinsurance</b>	
<b>Hospitalization</b>			
	Emergency Services Copay (copay waived if admitted)	\$200 designated facility / \$200 non-designated facility	
	Inpatient services/Outpatient surgery	Deductible and Coinsurance apply	
<b>Preventive Care</b>		<b>Not subject to deductible or coinsurance</b> 100%	
<b>Vision</b>		<b>Not subject to deductible or coinsurance</b>	
	Eye Exam	\$20 copay 1 per 12 months, 100%	
	Hardware	Up to \$150 in 12-month period for age 19+; (for age 18 & under, see Summary for details)	
<b>Prescriptions</b>		<b>IN-NETWORK ONLY - Not subject to deductible</b> <b>After 1<sup>st</sup> fill, maintenance drugs must be filled through KPWA mail order</b>	
	Supply Amount	Retail (30-day supply)	Mail Order (90-day supply)
	Preferred Generic	\$15 copay	\$5 copay
	Preferred Brand	\$35 copay	\$70 copay
	Preferred Specialty	Non-preferred generic/ brand not covered. \$150 copay, specialty medications only	Not covered – specialty and generic/ brand
	Pharmacy	Kaiser pharmacy	
<b>Virtual Care</b>		Covered in Full	
<b>Other Benefits</b>		See Kaiser Summary of Benefits for details	
<b>Monthly Rates</b>		<b>Virtual Plus Plan</b>	
		<b>Employee's contribution</b>	<b>PLU's contribution</b>
	<b>Employee Only</b>	<b>\$15.00</b> (was \$10.00)	<b>\$601.44</b> (was \$551.92)
	<b>Employee with a Spouse/DP</b>	<b>\$410.00</b> (was \$349.00)	<b>\$825.82</b> (was \$777.54)
	<b>Employee with Child(ren)</b>	<b>\$112.00</b> (was \$82.00)	<b>\$820.84</b> (was \$768.36)
	<b>Employee with Spouse/DP &amp; Child(ren)</b>	<b>\$429.00</b> (was \$377.00)	<b>\$820.20</b> (was \$761.78)

# PLU's Medical Plan Options effective 1/1/2024

		Kaiser Permanente HSA HMO	
<b>Providers</b>		<b>In-Network</b> See Kaiser website for locations and providers	
<b>Deductible</b> Deductible does not apply to preventive care. It does apply to all other services, including prescription drugs.		<b>Single (Employee Only)</b> \$1,600	<b>Family (Employee + Any Dependents)</b> \$3,200
<b>Out-of-Pocket (OOP) Limit</b>		<b>Single (Employee Only)</b> \$3,500	<b>Family (Employee + Any Dependents)</b> \$7,000
		Includes all cost shares for covered services (deductible, coinsurance & copays)	
<b>Lifetime Maximum</b>		Unlimited	
<b>Office Calls (Visits)</b>		Deductible and coinsurance apply No copay; 80%	
<b>Hospitalization</b>		Deductible and coinsurance apply	
Emergency Rm Copay		No copay; 80%	
Outpatient		80%	
Inpatient		80%	
<b>Preventive Care</b>		Not subject to deductible or coinsurance 100%	
<b>Vision</b>		Not subject to deductible or coinsurance	
Eye Exam		1 per 12 months, 100%	
Hardware		Not subject to deductible or coinsurance Up to \$250 in 12-month period for age 19+; (for age 18 & under, see Summary for details)	
<b>Manipulative Therapy (Chiropractic)</b>		Deductible and coinsurance apply 80% 10 visits per year	
<b>Prescriptions</b>		<b>IN-NETWORK ONLY</b> Subject to deductible (Copays apply only after deductible is met)	
Supply Amount		Retail (30-day supply)	Mail Order (90-day supply)
Preferred Generic		\$15 copay	\$45 copay
Preferred Brand		\$30 copay	\$90 copay
Non-Preferred Generic/Brand		Not covered	
Pharmacy		Kaiser pharmacy	
<b>Hearing Benefit</b>		Not covered on HSA plan, however, is an eligible expense reimbursed by the HSA account	
<b>Other Benefits</b>		See Kaiser Summary of Benefits for details	
Monthly Rates		HSA HMO	
		Employee's contribution	<b>PLU's contribution</b> (plus \$65.00/mo (\$780/yr) for HSA Individual \$130/mo (\$1,560/yr) for HSA Family deposited into Health Savings Account)
<b>Employee Only</b>		\$25.00 (was \$17.00)	\$534.00 (was \$496.30)
<b>Employee with a Spouse/DP</b>		\$295.00 (was \$229.00)	\$825.62 (was \$800.06)
<b>Employee with Child(ren)</b>		\$60.00 (was \$59.00)	\$785.92 (was \$717.82)
<b>Employee with Spouse/DP &amp; Child(ren)</b>		\$325.00 (was \$322.00)	\$807.74 (was \$718.20)

This is a brief comparison of the medical/vision plans' major benefit provisions. It is not intended to provide you with a full description. All benefits are subject to the terms and conditions of the group medical coverage agreement. If you have questions about a particular benefit, please contact PLU's Human Resources at x7185.