Clackamas Community College OEBB 2023-2024 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	NA	$1,600[2]	NA
Maximum deductible per family	None	NA	$2,400	NA	$3,200[2]	NA
Out-of-pocket (OOP) maximum per person [3]	$1,500	NA	$4,000	NA	$6,550[2]	NA
Out-of-pocket (OOP) maximum per family [3]	$3,000	NA	$12,000	NA	$13,100[2]	NA
Preventive Care Services						
Wellness Visit	$0	NA	$0[1]	NA	$0[1]	NA
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[1]	Not covered	$0[1]	Not covered
Office Visits and Virtual Care						
Primary care office visits	$20	Not covered	$25[1]	Not covered	20% after deductible	Not covered
Virtual Care	$0	Not covered	$0[1]	Not covered	$0 after deductible	Not covered
Specialist office visits	$30	Not covered	$35[1]	Not covered	20% after deductible	Not covered
Urgent care	$35	See Plan Handbook	$40[1]	See Plan Handbook	20% after deductible	See Plan Handbook
Mental Health Services						
Mental health office visits	$20	Not covered	$25[1]	Not covered	20% after deductible	Not covered
Mental health inpatient and residential services	$100 per day, up to $500 per admission max	Not covered	20% after deductible	Not covered	20% after deductible	Not covered
Chemical dependency services (inpatient, outpatient, or residential)	$0	Not covered	$0[1]	Not covered	20% after deductible	Not covered
Outpatient Services						
Outpatient surgery/facility care	$75	Not covered	20% after deductible	Not covered	20% after deductible	Not covered
Outpatient rehabilitation (physical, occupational & speech therapy)*	$30 per visit	Not covered	$35[1] per visit	Not covered	20% after deductible	Not covered
Tests (outpatient)						
Labs, x-ray, and imaging	$20 per visit	Not covered	$25[1] per visit	Not covered	20% after deductible	Not covered
CT, MRI, PET scans	$20 per visit	Not covered	$25[1] per visit	Not covered	20% after deductible	Not covered
Alternative Care Services[8]						
Acupuncture, chiropractic & naturopathic services[7]	$20 per service	Not covered	$25[1] per service	Not covered	20% after deductible	Not covered
Maternity Care						
Outpatient maternity care	$0	Not covered	$0[1]	Not covered	$0[1]	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% after deductible	Not covered	20% after deductible	Not covered
Hospital Services						
Inpatient care/surgery	$100 per day, up to $500 per admission max	See Plan Handbook	20% after deductible	See Plan Handbook	20% after deductible	See Plan Handbook
Skilled nursing facility care*	$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	
Ambulance	$75		$100[1]		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	10%	Not covered	10%[1]	Not covered	20% after deductible	Not covered
Durable medical equipment (DME)	20%	Not covered	20%[1]	Not covered	20% after deductible	Not covered

Clackamas Community College OEBB 2023-2024 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**	
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% 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[4]	$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[4]	$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						
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[4]	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	$693.73	$574.50	$423.09
Employee + Spouse/Partner	$1,526.21	$1,264.70	$931.34
Employee + Child(ren)	$1,318.09	$1,091.49	$803.53
Employee + Family	$2,150.57	$1,781.81	$1,311.82
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.			

NA = Not applicable

[1] Deductible waived

[2] 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 [1] indicates deductible waived).

[4] A formulary exception must be approved for non-preferred brand prescription medication.

[7] Acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year.

*** 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.**