KAISER PERMANENTE®

AURORA PUBLIC SCHOOLS – MEDICAL PLAN OVERVIEW (July 1, 2023 – June 30, 2024)

BENEFIT	Kaiser Permanente DHMO $1,000	Kaiser Permanente DHMO $2,500	Kaiser Permanente HDHP $1,500	Kaiser Permanente HDHP $3,000
Deductible				
Individual	$1,000 (Embedded)	$2,500 (Embedded)	$1,500 (Aggregate)	$3,000 (Embedded)
Family	$3,000 (Embedded)	$7,500 (Embedded)	$3,000 (Aggregate)	$6,000 (Embedded)
Out-of-Pocket Maximum	Includes Deductible	Includes Deductible	Includes Deductible	Includes Deductible
Individual	$4,000 (Embedded)	$4,000 (Embedded)	$4,000 (Aggregate)	$5,000 (Embedded)
Family	$9,000 (Embedded)	$9,000 (Embedded)	$6,850 (Aggregate)	$10,000 (Embedded)
Routine OVC	$25 Copay(1)	$25 Copay(1)	10% Coinsurance after deductible	20% Coinsurance after deductible
Specialty OVC	$50 Copay(1)	$50 Copay(1)	10% Coinsurance after deductible	20% Coinsurance after deductible
Preventive Care	No Charge	No Charge	No Charge	No Charge
Maternity				
Prenatal Care	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
Inpatient/Delivery	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% 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
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
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
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
Inpatient Hospital	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
Outpatient / Ambulatory Care	$500 Ambulatory Surgical Center / 10% after deductible at Plan Hospital	$500 Ambulatory Surgical Center / 20% after deductible at Plan Hospital	0% after deductible at Ambulatory Surgical Center / 10% after deductible at Plan Hospital	10% after deductible at Ambulatory Surgical Center / 20% after deductible at Plan Hospital
Laboratory	No Charge	No Charge	10% Coinsurance after deductible	20% Coinsurance after deductible
X-Ray	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
MRI/CAT/PET	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
Emergency Care	$300 Copay	$300 Copay	10% Coinsurance after deductible	20% 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
Urgent Care	$50 Copay(2,3)	$50 Copay(2,3)	10% Coinsurance after deductible(2,3)	20% Coinsurance after deductible(2,3)
Mental Health & Substance Abuse				
Inpatient Hospital	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
Outpatient Care	$25 Copay	$25 Copay	10% Coinsurance after deductible	20% 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	20% Coinsurance after deductible
Durable Medical Equipment	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
Oxygen	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
Organ Transplant	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
Home Health Care	10% Coinsurance after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible
Hospice Care	No Charge	No Charge	10% Coinsurance after deductible	20% 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;	20% Coinsurance after deductible;
Vision Care	$25 Copay; exam only(1)	$25 Copay; exam only(1)	10% Coinsurance after deductible	20% Coinsurance after deductible
Chiropractic Services	$25 Copay up to 10 visits per year	$25 Copay up to 10 visits per year	$25 Copay up to 10 visits per year	$25 Copay up to 10 visits per year
Acupuncture Services	$25 Copay up to 10 visits per year	$25 Copay up to 10 visits per year	$25 Copay up to 10 visits per year	$25 Copay up to 10 visits per year
Infertility (IVF, IUI, GIFT, ZIFT)	Applicable Plan Cost Share for Medical and Rx Listed Above	Applicable Plan Cost Share for Medical and Rx Listed Above	Applicable Plan Cost Share for Medical and Rx Listed Above	Applicable Plan Cost Share for Medical and Rx Listed Above
Hearing Exam	$25 Copay; exam only(1)	$25 Copay; exam only(1)	10% Coinsurance after deductible	20% Coinsurance after deductible

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.

3) Cost share for services such as, but not limited to X-rays, laboratory tests and office administered drugs may apply.

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