Kaiser Permanente

MBA Plans 4/1/21 - 3/31/22

Rates Effective: 4/1/2021 - 3/31/2022	KAISER GOLD	KAISER GOLD PPO	KAISER SILVER	KAISER BRONZE	KAISER H.S.A.
Deductible	$1,000	$1,000	$1,500	$3,000	$5,000
Family Deductible	$3,000	$3,000	$4,500	$9,000	$10,000
Out-of-Pocket Maximum	$4,000	$4,000	$4,000	$7,350	$6,750
Family Out-of-Pocket Maximum	$12,000	$8,000	$8,000	$14,700	$13,300
Network	Kaiser Facilities	T1: Kaiser T2: First Choice T3: Non	Kaiser Facilities	Kaiser Facilities	Kaiser Facilities
Out of Network Benefit	Emergency Hospital Only	T2: $2,000 Ded; $6,000 OOPM T3: $3,000 Ded, then 60% to $7,500	Emergency Hospital Only	Emergency Hospital Only	Emergency Hospital Only
Physician Expenses	***Indicates Deductible Waived**	***Indicates Deductible Waived**	***Indicates Deductible Waived**	***Indicates Deductible Waived**	***Indicates Deductible Waived**
Office Visits (other than Preventive)	$25 Copay* (Virtual $0*)	$25 Copay* (Virtual $0*) (T2: $35*)	$20 Copay* (Virtual $0*)	$30 Copay* (Virtual $0*)	50% Coinsurance
Specialist Visits	$35 Copay* (Virtual $0)	$35 Copay* (T2: $45*)	$20 Copay* (Virtual $0*)	$35 Copay* (Virtual $25*)	50% Coinsurance
Outpatient Mental Health	$25 Copay*	$25 Copay* (T2: $35*)	$20 Copay*	$30 Copay*	50% Coinsurance
Facility Expenses					
Inpatient Hospital	20% Coinsurance	20% Coinsurance (T2: 30%)	30% Coinsurance	20% Coinsurance	50% Coinsurance
Outpatient Hospital / Ambulatory Ce	20% Coinsurance	20% Coinsurance (T2: 30%)	30% Coinsurance	20% Coinsurance	50% Coinsurance
Other Expenses					
ER	$250 Copay	$200 Copay	$250 Copay	20% Coinsurance	50% Coinsurance
Urgent Care	$45 Copay*	$50 Copay* (T2: $100*)	$20 Copay* (Virtual $0*)	20% Coinsurance	50% Coinsurance
Lab & X-Ray (other than Preventive)	$25 Copay*	$25 Copay* (T2: $35 Copay*)	30% Coinsurance	$30 Copay*	50% Coinsurance
MRI & CT Scans	$100 Copay *	$100 Copay* (T2: 30%)	30% Coinsurance	$100 Copay *	50% Coinsurance
Pharmacy (30 day supply)	**Deductible Waived**	**Deductible Waived**	**Deductible Waived**	**Deductible Waived**	**After Deductible**
Generic	* $20 Copay	* $15 Copay / (T2 *$20 Copay)	* $20 Copay	* $20 Copay	$15 Copay
Formulary Brand Name	* $40 Copay	* $30 Copay / (T2 *$40 Copay)	* $40 Copay	* $40 Copay	$30 Copay
Non Formulary Brand Name	* $60 Copay	* $50 Copay / (T2 *$60 Copay)	* $60 Copay	* $60 Copay	$50 Copay
Vision Exam	$25 Copay*	$25 Copay* (T2: $35 Copay*)	$25 Copay*	$30 Copay*	50% Coinsurance
Vision Lenses & Frames	$150 Allowance	$150 Allowance	$150 Allowance	$150 Allowance	50% Coinsurance
Alternative Care					
Alternative Care Definition	Chiropractic, Acupuncture, Massage	Chiropractic, Acupuncture, Massage	Chiropractic, Acupuncture, Massage	Not Covered	Not Covered
Alternative Care Benefit	$20 Copay*; $1500 Annual Max	$20 Copay*; $1500 Annual Max	$20 Copay*; $1500 Annual Max		1000.0%

Final rates are based on final enrollment. Medical premiums shown include a $3.25 per employee administrative charge, $1.50 of which goes to the MBA.
This summary was designed for comparison purposes only. For detailed benefit summaries go to: www.aldrichadvisors.com/services/employee-benefits/mba

Aldrich.