Keenan

Alvord Unified School District

RENEWAL 2023

Effective Date	7/1/2023	7/1/2023	
Renewal Date	7/1/2024	7/1/2024	
Carrier	**Kaiser Permanente**	**Anthem Blue Cross**	
Plan Name	DHMO	PPO	
Benefit Summary	**Certificated**	**Certificated**	
		In-Network	**Out-of-Network**
General Plan Information			
Annual Deductible/Individual	$250	$250	$500
Annual Deductible/Family	$500	$500	$1,500
Coinsurance	10%	20%	40%
Office Visit/Exam	$10 copay: deductible doesn't apply	$20/visit (deductible waived)	40% coinsurance (deductible applies)
Outpatient Specialist Visit	$10 copay: deductible doesn't apply	$20/visit (deductible waived)	40% coinsurance (deductible applies)
Routine Exam	No charge	No charge	40%
Annual Out-of-Pocket Limit/Individual	$2,500	$2,500 /insured person/per year	$5,000 /per insured person/per year
Annual Out-of-Pocket Limit/Family	$5,000	$5,000/per insured person/per year	$14,300/per insured person/per year
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services			
Inpatient Hospitalization	10% after deductible	$250 copay per admission then 0% coinsurance after deductible is met.	$250 copay per admission then 40% coinsurance after deductible is met; limited to $1,000/day non-emergency admission. Copay is $500 if preauthorization is not received.
Semi-Private Room & Board; Including Services and Supplies	10% after deductible		
Outpatient Services			
Outpatient Surgery	10% after deductible	100% after deductible is met	40% after deductible is met
X-Ray and Laboratory Tests	$10 per encounter after deductible	100%	40% after deductible is met
MRI, Most CT and PET scans	10% up to maximum of $150 per procedure after deductible	100%	40% after deductible is met
Urgent Care Services			
Consultation, Evaluation and Treatment	$10 copay: deductible doesn't apply	$30 copay per visit (deductible waived)	40% coinsurance
Emergency Services			
Emergency Room	10% after deductible; waived if admitted	$250 copay after deductible is met; waived if admitted	$250 copay after deductible is met; waived if admitted
Ambulance Services	$150 per trip after deductible	100%	100%
Mental Health Benefits			
Inpatient Care	10% after deductible	$250 per admission then 0% coinsurance after deductible is met.	$250 copay per admission then 40% coinsurance after deductIbe is met; limited to $1,000/day non-emergency admission
Outpatient Care	$10 copay: deductible doesn't apply	$20 copay per visit; deductible waived	40% coinsurance; deductible applies.
Other Benefits			
Physical, Occupational and Speech Therapy	$10 copay after deductible	$20 for physical and occupational; $0 for speech	40%
Durable Medical Equipment	20%; deductible doesn't apply	20% after deductible is met	40% after deductible is met
Diagnosis and Treatment of Infertility	50%; deductible doesn't apply	Not available	Not available
Prescription Drug Benefits		**Tier 1**	**Tier 2**
Prescription Drug Deductible	None	None	None
Generic	$10 copay for a 30-day supply	$20 copay for a 30-day supply	$15 copay in addition to regular copay for a 30-day supply
Brand	$30 copay for a 30-day supply	$55 copay; if generic available member will pay copay and difference in cost between generic and brand drug for a 30-day supply	50% plus $15 copay in addition to regular copay if generic available member will pay copay and difference in cost between generic and brand drug for a 30-day supply
Specialty	20% up to $250 maximum for a 30-day supply	Not available	Not available
Mail Order			
Generic	$20 copay for a 100-day supply	$40 copay for a 90-day supply	Not available
Brand (Formulary/Preferred)	$60 copay for a 100-day supply	$110 copay if generic available member will pay copay and difference in cost between generic and brand drug for a 90-day supply	Not available
Specialty	Not applicable	$110 copay for a 90-day supply	Not available
Other Services and Supplies			
Chiropractic Services	$30 copay/20 visits per calendar year	$30 copay/30 visits per calendar year	40% after deductible is met

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