Oak Grove School District - 2022 Kaiser Plan Compare

	San Mateo JPA-Option 1	Oak Grove/SMCSIG JPA Opt 6	San Mateo JPA-Option 3
Carrier Name	**Kaiser Permanente**	**Kaiser Permanente**	**Kaiser Permanente**
Plan Name	HMO Plan A	HMO Plan B	Deductible HMO Plan D
General Plan Information			
Annual Deductible: Individual / Family	$0 / $0	$0 / $0	$1,000 / $2,000 (paid with HIPP)
Coinsurance	No Charge	No Charge	80%
Office Visit/Exam/Specialist	$15 copay	$30 copay	$20 copay (deductible doesn't apply)
Annual Out-of-Pocket Limit: Individual / Family	$1,500 / $3,000	$1,500 / $3,000	$3,000 / $6,000
Outpatient Services			
Preventive Services			
Adult Periodic Exams with Preventive Tests	No Charge	No Charge	No Charge
Well-Child Care	No Charge	No Charge	No Charge
Immunizations	No Charge	No Charge	No Charge
Well Woman Exams	No Charge	No Charge	No Charge
Mammograms	No Charge	No Charge	No Charge
Diagnostic X-Ray and Lab Tests	No Charge	No Charge	$10 copay (deductible doesn't apply)
Outpatient Facility Charge	$15 copay	$30 copay	20% after deductible
Outpatient Rehabilitative Therapy Services (Physical/Occupational/Speech)	$15 copay	$30 copay	$20 copay (deductible doesn't apply)
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal Care)	No Charge	No Charge	No Charge (deductible doesn't apply)
Inpatient Hospital Services			
Inpatient Hospitalization	No Charge	No Charge	20% after deductible
Emergency Services			
Emergency Room	$50 copay waived if admitted	$100 copay waived if admitted	20% after deductible
Ambulance	No Charge	$50 copay	$150 per trip (deductible doesn't apply)
Urgent Care Facility	$15 copay	$30 copay	$20 copay (deductible doesn't apply)
Mental Health & Substance Abuse Benefits			
Inpatient Care	No Charge	No Charge	20% after deductible
Outpatient Care	$15 copay	$30 copay	$20 copay (deductible doesn't apply)
Prescription Drug Benefits			
Retail			
Generic	$5 copay	$10 copay	$10 copay
Brand	$20 copay	$25 copay	$30 copay
Number of Days Supply	30 days	100 days	30 days
Mail Order			
Generic	$10 copay	$10 copay	$20 copay
Brand	$40 copay	$25 copay	$60 copay
Number of Days Supply for Mail Order	100 days	100 days	100 days
Other Services and Supplies			
Durable Medical Equipment & Prosthetic Devices	No Charge	20%	20% (deductible doesn't apply)
Home Health Care limited to 100 visits per year	No Charge	No Charge	No Charge (deductible doesn't apply)
Skilled Nursing or Extended Care Facility limited to 100 days per benefit period	No Charge	No Charge	20% (deductible doesn't apply)
Hospice Care	No Charge	No Charge	No Charge (deductible doesn't apply)
Vision	Eyeglasses or contact lenses every 24 months, $125 allowance	Eyeglasses or contact lenses every 24 months, $125 Allowance	Not Covered
Chiropractic/Acupunture	$15 copay (Up to a combined total of 20 medically necessary Chiropractic and Acupuncture visits per year)	$10 copay (Up to a combined total of 30 medically necessary Chiropractic and Acupuncture visits per year)	$15 copay (Up to a combined total of 30 medically necessary Chiropractic and Acupuncture visits per year)
Diagnosis/Treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests)	50%	$30 copay	50% (deductible doesn't apply)
Assisted Reproductive Technology Services	Not Covered	Not Covered	Not Covered
2022 Premium Rates	**Effective January 1, 2022**		
Single	$770.29	$747.05	$683.60
Two Party	$1,540.57	$1,494.10	$1,366.21
Family	$2,179.91	$2,114.16	$1,935.15