

Oak Grove School District



2025 Kaiser Plan Comparison

Carrier	Kaiser	Kaiser	Kaiser
Plan Name	Plan A \$15 Copay	Plan B \$30 Copay	Plan D \$20 Copay with Deductible
Benefit Summary	All Employees	All Employees	All Employees
General Plan Information			
Annual Deductible / Individual	\$0	\$0	\$1,000 (HIPP Rider Available)
Annual Deductible / Family	\$0	\$0	\$2,000 (HIPP Rider Available)
Coinsurance	100%	100%	80%
Office Visit / Exam	\$15 copay	\$30 copay	\$20 copay (no deductible)
Out Patient Specialist Visit	\$15 copay	\$30 copay	\$20 copay (no deductible)
Annual Out-of-Pocket Maximum / Individual	\$1,500 (includes Rx)	\$1,500 (includes Rx)	\$3,000 (includes Rx)
Annual Out-of-Pocket Maximum / Family	\$3,000 (includes Rx)	\$3,000 (includes Rx)	\$6,000 (includes Rx)
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
Primary Care Physician Required	Yes	Yes	Yes
Outpatient Services			
Preventive Services			
Adult Periodic Exams with Preventive Tests	100%	100%	100%
Well-Child Care	100%	100%	100%
Immunizations	100%	100%	100%
Well Woman/Mammogram Exams	100%	100%	100%
Diagnostic X-Ray / Lab Tests (Non-Preventive)	100%	100%	\$10 copay
Vision / Hearing Screening	100%	100%	100%
Outpatient Facility Charge	\$15 copay	\$30 copay	80%, after deductible
Outpatient Rehabilitative Therapy	\$15 copay	\$30 copay	\$20 copay
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%	100%
Inpatient Hospital Services (Pre-Authorization Required)			
Inpatient Hospitalization	100%	100%	80%, after deductible
Emergency Services			
Emergency Room	\$50 copay, waived if admitted	\$100 copay, waived if admitted	80%, after deductible
Ambulance / Air & Ground	100%	\$50 per trip	\$150 per trip
Urgent Care Facility	\$15 copay	\$30 copay	\$20 copay
Mental Health / Substance Abuse Benefits			
Inpatient Care	100%	100%	80%, after deductible
Outpatient Care	\$15 copay	\$30 copay	\$20 copay

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2025 Kaiser Plan Comparison Continued

Carrier	Kaiser	Kaiser	Kaiser
Plan Name	Plan A \$15 Copay	Plan B \$30 Copay	Plan D \$20 Copay with Deductible
Benefit Summary	All Employees	All Employees	All Employees
Prescription Drug Benefits			
Retain Pharmacy			
Generic	\$5 copay	\$10 copay	\$10 copay
Brand (Formulary / Preferred)	\$20 copay	\$25 copay	\$30 copay
Brand (Non-Formulary / Non-Preferred)	\$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 (Formulary / Preferred)	\$40 copay	\$25 copay	\$60 copay
Brand (Non-Formulary / Non-Preferred)	\$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	100%	80%	80%
Home Health Care	100%	100%	100%
Skilled Nursing or Extended Care Facility	100% up to 100 days / calendar year	100% up to 100 days / calendar year	80%, up to 100 days
Hospice Care	100%	100%	100%
Chiropractic	\$15 copay, up to 20 visits / combined with acupuncture	\$10 copay, up to 30 visits	\$15 copay, up to 30 visits / combined with acupuncture
Acupuncture	\$15 copay, up to 20 visits / combined with chiropractic	Not Covered	\$15 copay, up to 30 visits / combined with chiropractic
Hearing Aids (Every 36 months for both ears)	\$500 Allowance/device; 1 device per ear;	Not Covered	Not Covered
Vision (Adult and Child)	2 device(s)/36months No charge for exam;	No charge for exam;	No charge for exam;
Infertility - Diagnosis & Treatment	\$125 allowance for glasses every 24 months 50% of covered charges	\$125 allowance for glasses every 24 months \$30 copay	No benefit for glasses \$30 copay