GINGERICH INSURANCE SOLUTIONS

PATTERSON JOINT UNIFIED SCHOOL DISTRICT

KAISER PERMANENTE®

Kaiser Permanente Health Plans
October 1, 2025 - September 30 2026

BENEFIT Member Responsibility	Kaiser Plan 1	Kaiser Plan 2	Kaiser HSA Plan
Pre-Loaded Benefit Card	Ind: $3,300 Fam: $6,200	Ind: $2,300 Fam: $4,200	**Pre-Loaded Benefit Card Does Not Apply**
Use Your Pre-Loaded Benefit Card To Pay For All Services Until The Card Is Exhausted. All Benefits Below Refelct The Member's Out-Of-Pocket Cost Once The Benefit Card Is Exhausted.			
Calendar Year Out-of-Pocket Maximum	Ind: $0 Fam: $0	Ind: $1,200 Fam: $2,000	Ind: $3,300 Fam: $6,200
Calendar Year Deductible	Ind: $0 Fam: $0	Ind: $0 Fam: $0	Ind: $2,000 Fam: $3,300/$4,000
Coinsurance	No Charge	20%	20% After Deductible
Preventive Care/Immunizations	No Charge	No Charge	No Charge
Doctor Visits (Primary Care)	$0	$30 Copay Per Visit	$30 Copay Per Visit After Deductible
Doctor Visits (Specialists)	$0	$30 Copay Per Visit	$30 Copay Per Visit After Deductible
Urgent Care	$0	$30 Copay Per Visit	$30 Copay Per Visit After Deductible
Teledoc-Medical Services	No Charge	No Charge	No Charge After Plan Deductible
Chiropractic	$0 (20 vists per year)	$15 Copay Per Visit (20 visits per year)	$15 Copay Per Visit After Deductible (20 visits per year)
Physical Therapy	$0	$30 Copay Per Visit	$30 Copay Per Visit After Deductible
Infertility	$0	Covered	Covered
Prescription Drugs (Tier 1)	$0	$10 Copay (30 Day Supply)	$10 Copay After Deductible (30 Day Supply)
Prescription Drugs (Tier 2)	$0	$30 Copay (30 Day Supply)	$30 Copay After Deductible (30 Day Supply)
Prescription Drugs (Tier 4)	$0	20% not to exceed $150 (30 Day Supply)	20% not to exceed $150 After Deductible (30 Day Supply)
Mail Order Tier 1	$0	$20 Copay (100 Day Supply)	$20 Copay After Deductible (100 Day Supply)
Mail Order Tier 2	$0	$60 Copay (100 Day Supply)	$60 Copay After Deductible (100 Day Supply)
Hospital Emergency Room	$0	$100 Copay Per Visit	$100 Copay Per Visit After Deductible
Hospital Inpatient	$0	$250 Copay per admission	$250 Copay per admission After Deductible
Outpatient Surgery	$0	$150 Copay Per Procedure	$150 Copay Per Procedure After Deductible
Home Health Care	$0	No Charge (Limited to 100 Days Per Calendar Year)	No Charge After Deductible (Limited to 100 Days Per Calendar Year)
Outpatient Diagnostic Tests/Imaging	$0	$50 Copay Per Procedure	$50 Copay Per Procedure After Deductible
Radiation Therapy Chemotherapy	$0	$150 Copay	$150 Copay After Deductible
Durable Medical Equipment	$0	20%	20% After Deductible
Ambulance-Ground/Air	$0	$100 Copay Per Trip	$100 Copay Per Trip After Deductible
Mental Health/Substance Abuse Outpaitent	$0	$30	$30 After Deductible
Mental Health/Substance Abuse Inpaitent	$0	$250 Per Admission	$250 Per Admission After Deductible

2025-2026 Rates	Kaiser Plan 1	Kaiser Plan 2	Kaiser HSA Plan
Employee Only	$ 1,168.00	$ 1,117.00	$ 937.00
Employee + 1	$ 2,008.00	$ 1,920.00	$ 1,610.00
Employee + 2 or more	$ 2,532.00	$ 2,421.00	$ 2,030.00