

**Classified Election Form**  
**Kaiser Option for 2022-2023 Benefit Plan Year (Oct. 2022-Sept. 2023)**

<b>Brief Summary of Benefits</b>	<b>Member Pays:</b>
<b>Professional Services:</b>	
Office Visit co-pay	\$10
Urgent Care co-pay	\$10
Specialists/Consultants co-pay	\$10
Prenatal, Postnatal Office Visit co-pay	\$0
Scans: CT, CAT, MRI, PET, etc.	\$0
Diagnostic X-ray & Laboratory Procedures	\$0
Preventative Care Services (includes physical exams & screenings)	\$0
<b>Hospital &amp; Skilled Nursing Facility Services:</b>	
Emergency Room (co-pay waived if admitted)	\$100 co-pay
Inpatient Hospital co-pay (preauthorization required)	\$0
Outpatient Hospital co-pay	\$10
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	\$10
Surgery, Outpatient (performed in a Hospital)	\$10
<b>Mental Health Services &amp; Substance Abuse Treatment:</b>	
Inpatient Care: Facility based care (preauthorization required)	\$0
Outpatient Care: Facility based care (preauthorization required)	\$10
<b>Other Services:</b>	
Acupuncture - limits apply	\$10 co-pay / 30 visits
Ambulance (ground or air)	\$50
Chiropractic - limits apply	\$10 co-pay / 30 visits
Durable Medical Equipment (DME)	100%
Physical and Occupational Therapy - limits apply	\$10
<b>Individual / Family Deductible(s)</b> A portion of the covered expenses that an individual must pay before benefits are paid by the insurance plan - deductibles are per calendar year.	<b>\$0</b>
<b>Individual / Family - Out of Pocket Max (OOP Max)</b> - The OOP Max is the most you have to pay in deductibles, co-insurance and co-pays for covered health services during a calendar year. All deductibles and co-pays apply to the calendar year OOP maximum.	<b>\$1500 per individual \$3000 family</b>
<b>Outpatient Prescription Drugs</b>	
<b>Days supply</b>	100
Generic Cost	\$10
Brand Name Cost	\$10
Mail Order	\$10

This sheet is only a brief summary of benefits that reflects In-Network benefits. Visit our website at [hr.fcoe.org/benefits](http://hr.fcoe.org/benefits) to review the benefit summaries or plan booklets for details, limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.

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<b>MONTHLY COSTS</b>	
Medical	\$1,297.00
TOTAL COST w/ Delta Dental Premier (Incentive) Plan	\$1,445.05
TOTAL COST w/ Delta Dental PPO Plan	\$1,433.05
Employer Contribution/Monthly	\$1,312.50

<b>11 MONTH EMPLOYEE COST</b>	
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$144.60
Employee's Cost/Monthly with Delta Dental PPO	\$131.51

<b>12 MONTH EMPLOYEE COST</b>	
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$132.55
Employee's Cost/Monthly with Delta Dental PPO	\$120.55

**Note: Monthly costs include: Medical, Dental, Vision, Life Insurance & Administrative Fee**

Delta Dental Premier (Incentive) Plan \_\_\_\_\_

Delta Dental PPO Plan \_\_\_\_\_

\_\_\_\_\_  
 Name (Please Print)

\_\_\_\_\_  
 Employee Signature

\_\_\_\_\_  
 Social Security Number (LAST 4 DIGITS)

\_\_\_\_\_  
 Date