Classified Election Form

Kaiser Option for 2023-2024 Benefit Plan Year (Oct. 2023-Sept. 2024)

Brief Summary of Benefits	Member Pays:
Professional Services:	
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
Hospital & Skilled Nursing Facility Services:	
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
Mental Health Services & Substance Abuse Treatment:	
Inpatient Care: Facility based care (preauthorization required)	$0
Outpatient Care: Facility based care (preauthorization required)	$10
Other Services:	
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
Individual / Family Deductible(s) A portion of the covered expenses that an individual must pay before benefits are paid by the insurance plan - deductibles are per calendar year.	**$0**
Individual / Family - Out of Pocket Max (OOP Max) - 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.	**$1500 per individual** **$3000 family**
Outpatient Prescription Drugs	
Days supply	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 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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MONTHLY COSTS	
Medical	$1,391.00
TOTAL COST w/ Delta Dental Premier (Incentive) Plan	$1,530.95
TOTAL COST w/ Delta Dental PPO Plan	$1,518.95
Employer Contribution/Monthly	$1,412.50

11 MONTH EMPLOYEE COST	
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	$129.22
Employee's Cost/Monthly with Delta Dental PPO	$116.13

12 MONTH EMPLOYEE COST	
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	$118.45
Employee's Cost/Monthly with Delta Dental PPO	$106.45

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