

Classified Benefits Information Sheet
Kaiser Option for 2026-2027 Benefit Plan Year (Oct. 2026-Sept. 2027)

| 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 | \$1,749.00 |
| TOTAL COST w/ Delta Dental Premier (Incentive) Plan | \$1,888.95 |
| TOTAL COST w/ Delta Dental PPO Plan | \$1,876.95 |
| Employer Contribution/Monthly | \$1,620.83 |

| 11 MONTH EMPLOYEE COST | |
|--|----------|
| Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan | \$292.49 |
| Employee's Cost/Monthly with Delta Dental PPO | \$279.40 |

| 12 MONTH EMPLOYEE COST | |
|--|----------|
| Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan | \$268.12 |
| Employee's Cost/Monthly with Delta Dental PPO | \$256.12 |

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