Kaiser Permenante Vision Plan

	In-Network	Out-of-Network
Eye Exam WellVision Exam Overall Wellness	$10 total co-pay for exam and glasses	Reimbursed up to $45 International reimbursed up to $65
Lenses Shatter resistant Scratch resistant coating Anti-reflective coating Tints UV protection In and outdoors lenses	$10 co-pay for exam and glasses $0 $0 $0 $0 $0 $0	Reimbursed up to: Single vision $45 Lenticular $125 International reimbursement: Single Vision $55 Lenticular $125
Frames	Covered up to $200	Reimbursed up to $47 International Reimbursement up to $120
Contact Lenses	Plan pays up to $150 allowance for contacts Contact lens exam (fitting and evaluation) up to $55 co-pay	Reimbursed up to $105 International up to $105
Extra Savings Perscription Glasses Average 20%-25% savings on all other lens enchancements Contacts 15% savings on the cost of contact lens exam	Available	Not Available

HIGHLIGHTS OF THE PLAN. IF YOU HAVE ANY QUESTIONS PLEASE COME VISIT THE HUMAN RESOURCES DEPARTMENT

Price for Vision Plan
$14.43

Select the plan you would like apply:

☐ Would like the plan and will pay $14.43

☐ No, I would not this plan

I agree to enroll into the Kaiser Vision Plan. **By signing this form you understand this plan and are responsible for the payment**

Name:_____
(Print Name)

Date:_____/_____/_____

Signature:_____

If you would not like the plan above please sign the form stating that you **understand that you were offered the plan but have chosen to deny the option**

Name:_____
(Print Name)

Date:_____/ _____/ _____

Signature:_____

Cigna Dental Plan

	In-Network	Out-of-Network
Individual Calendar Year Deductible	$50 per person	$50 per person
Preventive Services Oral Exams Routine Cleanings Routine x-rays Sealants Fluoride Treatment Space maintainers	$0	The difference between the provider's standard fee and 100% of the MAC
Basic Services Non-routine x-rays Fillings Routine Tooth Extraction Emergency Treatment	20% of the provider's contracted fee	The difference between the provider's standard fee and 80% of the MAC
Major Services Periodontal Crowns Root Canal Wisdom Tooth Extraction	50% of the provider's contracted fee	The difference between the provider's standard fee and 50% of the MAC
Orthodontia	100% of the provider's stnadard fee	100% of the provider's standard fee
Limitations Basic Restorative Services Major Restorative Services	6-month waiting period 12-month waiting period	Not applicable

HIGHLIGHTS OF THE PLAN. IF YOU HAVE ANY QUESTIONS PLEASE COME VISIT THE HUMAN RESOURCES DEPARTMENT

Price for Dental Plan
$42

Select the plan you would like to apply:

☐ Would like the plan and will pay $42

☐ No, I would not this plan

I agree to enroll into the Dental Plan. **By signing this form you understand this plan and are responsible for the payment**

Name:_____
(Print Name)

Date:_____/_____/_____

Signature:_____

If you would not like the plan above please sign the form stating that you **understand that you were offered the plan but have chosen to deny the option**

Name:_____
(Print Name)

Date:_____/ _____/ _____

Signature:_____

Kaiser Permenante HMO Plan

Medical Plan Benefits	Deductible
Annual Medical Deductible (individual/family)	$1,000/$2,000
Annual Out-of-Pocket Maximum(Individual/Family)	$7,550/$15,000
Emergency After Urgent Care Emergency Department Visit	35%(after the deductible)
Ambulance	35%(after the deductible)
Prescription Drugs(up to a 30-day supply) Preferred Generic	$30
Preferred Brand	$75(after $250 drug deductible)
Speciality	20% per prescription up to $250 maximum(after $250 drug deductible)
Impatient Hospital Care Room and board, surgery, anesthesia, X-rays, lab test, medications, mental health care	35%(after the deductible)
Skilled nursing facility care (100 days per benefit period)	35%(after the deductible)

HIGHLIGHTS OF THE PLAN. IF YOU HAVE ANY QUESTIONS PLEASE COME VISIT THE HUMAN RESOURCES DEPARTMENT

Price for HMO Plan
$283.23

Select the plan you would like to apply:

☐ Would like the plan and will pay $283.23

☐ No, I would not this plan

I agree to enroll into the HMO Plan. **By signing this form you understand this plan and are responsible for the payment**

Name:_____
(Print Name)

Date:_____/_____/_____

_

Signature:_____

If you would not like the plan above please sign the form stating that you **understand that you were offered the plan but have chosen to deny the option**

Name:_____
(Print Name)

Date:_____/ _____/ _____

Signature:_____

Kaiser Permanente PPO Plan

Medical Plan Benefits	In-Network	Out-of-Network
Visits Primary Care Visit (for illness or injury) Special Visit	$45 per visit,deductible does not apply $80 per visit, deductible does not apply	40% Coinsurance
Immunization	No Charge	40% Coinsurance
Diagnostic Test (x-ray,bloodwork)	x-ray: $75 per tet Lab tests: $40 per test	40% Coinsurance
Drugs Preferred Brand Drugs Non-Preferred Brand Drugs	MedImpact: $15 per prescription Mail Order: $110 per prescription	Not Covered
Emergency Emergency room care emergency medical transportation	$350 per visit $250 per trip	$350 per visit $250 per trip
Facility Fee	20% coinsurance	40% coinsurance
Physician/Surgeon Fees	20% coninsurance	40% coninsurance

HIGHLIGHTS OF THE PLAN. IF YOU HAVE ANY QUESTIONS PLEASE COME VISIT THE HUMAN RESOURCES DEPARTMENT

Price for PPO Plan
$528.56

I agree to enroll into the PPO Plan. **By signing this form you understand this plan and are responsible for the payment**

Name:_____
(Print Name)

Date:_____/_____/_____

Signature:_____

Select the plan you would apply for:

☐ Would like the plan and will pay $528.56

☐ No, I would not this plan

If you would not like the plan above please sign the form stating that you **understand that you were offered the plan but have chosen to deny the option**

Name:_____
(Print Name)

Date:_____/ _____/ _____

Signature:_____