Extra Help
Health Benefits Options Summary 2017 Plan Year

	Kaiser HMO $15 / $0 Kaiser Hospitals	Anthem Blue Cross HMO $15 / $0 Community Hospitals	Kaiser DHMO 60% $4500 Deductible	Anthem Blue Cross PPO 80/60% $500 Deductible St. Agnes & Community	Anthem Blue Cross HDHP 100/50% $3000 / 6000 Deductible St. Agnes & Community
				Rates shown are for Preferred Providers	
				The Annual Medical Deductible must be paid except where noted as "waived", before medical insurance benefits are received from the health plan.	
Annual Deductible (Individual)	None	None	$4500/$9000	$500/$1000	$3000/$6000
Maximum out of Pocket (OOP) (annually, per individual/family)	$1500/$3000	$1000/$2000	$6000/$12000	$3,000/$6,000-PPO $10,000/20,000-NonPPO	$3,000/$6,000 -PPO $5,000/$10,000 - NonPPO
Provider Network	Kaiser	Sante	Kaiser	Anthem Blue Cross PPO	Anthem Blue Cross PPO
Maximum Lifetime Benefits (per individual)	unlimited	unlimited	unlimited	unlimited	unlimited
Hospitalization - inpatient	No charge	No Charge	40% per admit	$250 + 20%	No Charge
Hospital - outpatient	$15	No Charge	40%	$125 + 20%	No Charge
Office Visits - Primary Care Physician	$15	$15	40% /visit	$35 (deductible waived)	No Charge
Office Visits-Specialist	$15 (referral required)	$15	40%/visit	$35 (deductible waived)	No Charge
Preventative					
Laboratory & X-ray	No charge	No Charge	No charge	No charge, x-ray excluded	No Charge
Allergy Testing/Treatment	$15 Testing/$5 Treatement (serum included)	$15 copay serum & injections	40%	20%	No Charge
Hearing Exam/Screening	No Charge	No Charge	40%	No Charge, Deductible Waived	No Charge, Deductible Waived
Immunization/Inoculation	No Charge	No Charge	40%	No Charge, Deductible Waived	No Charge, Deductible Waived
Well Woman Exam	No Charge	No Charge	No charge	No Charge, Deductible Waived	No Charge, Deductible Waived
Annual Physical Exam	No Charge	No Charge	No charge	No Charge, Deductible Waived	No Charge, Deductible Waived
Well Baby Care	No Charge	No Charge	No charge	No Charge, Deductible Waived	No Charge, Deductible Waived
Inpatient Hospital Doctor Visits	No Charge	No Charge	40%	$250 + 20%	No Charge
Outpatient Surgery/Anesthesia	No Charge	No Charge	40%	20%	No Charge
Vision Exam (Refraction-Adult & Child)	No Charge	Not Covered	40%	Not Covered	Not Covered
Diagnostic X-ray & Labs (DXL)	$10	No Charge	40%	No Charge except MRI other scans	No Charge
Durable Medical Equipment (DME)	20% includes diabetic testing supplies	No Charge	40%	20%	No Charge
Covered Prescription Drugs (up to 1 mo supply)	$10 for generic $30 for brand, up to 100 days	$10 generic $20 formulary brand-name $35 non-formulary	30% generic (max $50); 40% brand (with $250 deductible);	$10 generic $20 formulary brand-name $35 non-formulary	No Charge
Covered Prescription Drugs Mail Order (up to 3 mos. supply)	$20 for generic $60 for brand name up to 100 day supply	$20 generic $40 formulary brand-name $60 non-formulary	30% generic (max $50); 40% brand (with $250 deductible);	$20 generic $40 formulary brand-name $60 non-formulary	No Charge
Ambulance	$100	No Charge	40%	20%	No Charge
Emergency Room	$100	$100	40%	$100 + 20%	No Charge
Mental Health - inpatient	No Charge	No Charge	40%	$250 per admission plus 20%	No Charge
Mental Health - outpatient	$15	$15	40%	$35	No Charge
Substance Abuse - inpatient	No Charge	No Charge	40%	$250 per admission plus 20%	No Charge
Substance Abuse - outpatient	$5 group visit, $15 individual visit	$15	40%	$35	No Charge
Home Health Services	No Charge 100 visits	$15, 100 Visits	40%	20% up to 100 per year	No Charge
Physical, Occupational, & Speech Therapy	$15	$15/visit - 60 day limit.	40%	$35	No Charge
Skilled Nursing Facility (SNF)	No charge up to 100 days	No Charge up to 100 day max	40% up to 100 days	20% up to 100 days	No Charge
Hospice	No Charge	No Charge	40%	No Charge	No Charge
Acupuncture	$15/visit, up to 30 per year, referral req	$10/visit 40 per year combined	Not covered	20%, up to 20 per year	No charge up to 12 per year
Chiropractic	$15/visit, up to 30 per year	$10/visit 40 per year combined	Not covered	$25/visit, up to 12 per year	No Charge up to 24 per year
Employee Assistance Plan	3 visits, individual or family, per 6 months. Psychological & Emotional, Marital Relationship, Parental Guidance, Substance Abuse, Work Performance, Legal & Financial referral. No co-pay.				

Extra Help Employee Cost Per Month - 2017 Plan Year

Coverage Type	Kaiser HMO $15 / $0	Anthem Blue Cross HMO $15 / $0	Kaiser DHMO 60%	Anthem Blue Cross PPO 80% / $500	Anthem Blue Cross HDHP 3000/6000
Medical & Prescription Coverage Only					
Employee Only	**$565.53**	**$616.53**	**$371.53**	**$651.53**	**$478.53**
Employee Plus Child(ren)	**$1,002.83**	**$1,108.83**	**$652.83**	**$1,173.83**	**$859.83**
Employee & Spouse	**$1,166.69**	**$1,292.69**	**$758.69**	**$1,366.69**	**$1,002.69**
Employee and Family	**$1,657.28**	**$1,846.28**	**$1,075.28**	**$1,951.28**	**$1,432.28**

The Kaiser DHMO plan is available to all PT employees beginning January 2014.

Employee must qualify for the other plans by working more than 20 hours/week in accordance with the Extra Help Benefit Summary.